Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA,

Petitioner,

v.

UNIBELL ANESTHESIA, P.C.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF NEW YORK, APPELLATE DIVISION, FIRST DEPARTMENT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. May an ERISA fiduciary be sued in state court, under state law, for allegedly misrepresenting acts it performed as an ERISA fiduciary?

2. May an action seeking damages against an ERISA fiduciary based upon an interpretation of the terms of an ERISA plan be maintained in state court, under state law?

3. May an action be maintained in state court, under state law, to determine what information must be disclosed by an insurer/ERISA fiduciary to the employer/plan administrator during the renewal of an ERISA plan?

4. Are constructive fraud, negligent misrepresentation, unjust enrichment, and a New York common law based statute which allows for rescission of insurance policies and a refund of all premiums paid, without an offset of claims paid, laws regulating insurance within the meaning of the ERISA savings clause?

5. May punitive damages be awarded against an ERISA fiduciary in state court, under state law, for performing acts related to its fiduciary duties?

STATEMENT PURSUANT TO RULE 29.6

There is no parent or publicly held company owning 10% or more of the stock of The Guardian Life Insurance Company of America.

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Petitioner, The Guardian Life Insurance Company of America, respectfully requests that a writ of certiorari be issued to review the order of the Supreme Court, State of New York, Appellate Division, First Department in this case. The New York Court of Appeals declined to review the order.

OPINION BELOW

The opinion of the Supreme Court, State of New York, Appellate Division, First Department is reported at *Unibell Anesthesia, P.C. v. The Guardian Life Insurance Company of America*, 682 N.Y.S.2d 193, 1998 N.Y. APP. DIV. LEXIS 13928. Leave to appeal was denied by the New York Court of Appeals, 1999 N.Y. LEXIS 1250.

STATEMENT OF JURISDICTION

The order of the New York Supreme Court, Appellate Division was entered on December 29, 1998 (Appendix A, 1a). The Appellate Division denied a timely motion of The Guardian Life Insurance Company of America for reargument by order dated February 11, 1999 (Appendix C, 12a). The New York Court of Appeals denied the timely motion of The Guardian Life Insurance Company of America for leave to appeal by order dated May 13, 1999 (Appendix D, 14a).

The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

STATUTES AND LAW INVOLVED

The statutes and law involved are 29 U.S.C. § 1132, § 1144 and New York Insurance Law § 4226. The relevant portions are in Appendix E, 16a.

STATEMENT OF THE CASE

In 1977, defendant, The Guardian Life Insurance Company of America ("Guardian"), issued a policy of group health insurance to plaintiff, Unibell Anesthesia, P.C. ("Unibell"), for the benefit of its employees and their dependents. The policy was an "employee welfare benefit plan" under the Employees Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*

The term of the contract was for one year. There was a provision for annual renewal at the option of the parties at a premium proposed by Guardian (607a; 623a).[1] The policy was renewed annually through the end of 1993. Guardian was an ERISA fiduciary. The policy provided that "Guardian is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims" (680a). The ERISA plan does not name a plan administrator (607a). In such a case Unibell, as the plan sponsor, is the administrator. 29 U.S.C. § 1002(16)(A)(ii).

In 1994 Unibell commenced this action in the Supreme Court, State of New York, County of New York, seeking recovery upon various state common law and statutory claims, based upon allegations that Guardian failed to disclose that a certain Unibell employee (Ms. Greta Filler), who suffered from a serious illness and had incurred high medical expenses, had become eligible for Medicare benefits. The theory of the case was that this information was concealed from Unibell and the effect of Medicare on the prospective risk of Guardian was not considered when annual premium rates were proposed by the insurer (17a).

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1. References are to the pages of the record on appeal to the New York Supreme Court, Appellate Division, First Department.

Guardian did not remove the case to the Federal District Court at that time since the allegations did not appear to implicate the obligations of Guardian as an ERISA fiduciary under existing federal law.

The action proceeded through discovery. Guardian's motion for summary judgment, on state law grounds, was denied. The denial was affirmed on appeal.

A few weeks prior to the scheduled trial date the parties exchanged proposed jury instructions. Unibell's proposed charges made an unpleaded argument the central focus of the case. This contention was that, in the 1991 ERISA plan renewal proposal, Guardian deliberately overstated the amount of claims paid during the 1990-1991 policy year to induce Unibell to renew the policy at an excessive premium. The renewal proposal stated that "incurred claims" for the prior policy year were $1,118,841.70 (132a).[2] Unibell contended that approximately $500,000 of the claims paid were charges for medical services rendered to Ms. Filler during policy years prior to 1990-91. It was contended that Guardian overstated the claims to induce Unibell to renew the plan at the proposed increased rates (*See, e.g.*, 1001a-1002a; 1031a-1032a).

Guardian immediately moved to preclude the introduction of any evidence on these issues at the impending trial upon the basis that the allegations charged Guardian with a breach of its duties as an ERISA fiduciary (34a). ERISA fiduciary breach claims are matters of exclusive federal subject matter jurisdiction. 29 U.S.C. § 1132(e).

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2. "Incurred claims" are the claims paid plus a reserve for unfiled claims less the beginning reserve (814-15). This is the standard National Association of Insurance Commissioners definition for claims reporting purposes in all fifty states (814-16).

In response to this motion, Unibell moved to add allegations to the amended complaint that the claims paid for 1990-91, as reported in the 1991 renewal proposal, included amounts that were paid during that policy year for medical services rendered to Ms. Filler during earlier policy years (60a). Ms. Filler had been hospitalized for several years. Due to a dispute between the hospital and the primary carrier (Blue Cross), charges in the amount of approximately $500,000 for services rendered during 1988-90 were not billed to Guardian until 1991 (267a). It was Unibell's theory that Guardian committed a fraudulent act by reporting such payments (made as an ERISA fiduciary) as 1991 claims.[3] Recovery was sought for common law fraud, constructive fraud, negligent misrepresentation, unjust enrichment, and for alleged violations of two New York statutes, together with punitive damages.

Unibell also contended that the 1991 claims reported in the renewal proposal were inflated by double counting, in that Unibell (erroneously) contended that Guardian included amounts paid for prior years' claims in the totals reported for the year the services were rendered *and* for the year claims for such services were paid.

Over Guardian's objection, Unibell was granted leave to amend the amended complaint, as requested, on the day the trial commenced (10). Allegations were added to the

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3. The ERISA contract stated that a "covered charge" resulted if a medical service was provided to an insured person when the policy was in force (646a). This protects an insured against the effects of a cancellation of the policy before a claim is made for such charges. As discussed in Point I, a claim cannot exist under the ERISA plan until a claim is filed with the insurer (628a). Unibell's new theory of recovery reversed these concepts.

complaint which contended that Guardian had engaged in a "fraudulent scheme . . . to obtain grossly excessive health insurance premium payments from plaintiff UNIBELL by misrepresenting the extent of GUARDIAN'S risk under a group health insurance plan issued by GUARDIAN for the employees of UNIBELL" (17a).

Guardian argued that the newly alleged wrongdoings related to the administration of an ERISA plan and, as such, were preempted by ERISA. The ERISA preemption arguments of Guardian were rejected by the trial court upon the basis that the newly alleged fraudulent activities occurred while Guardian was occupying the role of a seller of insurance, not while acting in its capacity as an ERISA claims fiduciary (8). The fact that the allegations related to Guardian's ERISA claims fiduciary status was not considered to be significant.

Guardian requested a recess to permit the filing of a removal petition. This was denied and the trial commenced immediately (11). The removal petition was filed later that day (972a). Unibell's motion to remand was granted by the United States District Court, Southern District of New York (Hon. John S. Martin, Jr.), upon the basis that "the notice of removal was not timely filed" (974a). As discussed, *infra*, this order necessarily implies a finding of ERISA preemption. The trial resumed in state court. Guardian was granted leave to amend its answer to respond to the new allegations which were added to the existing causes of action. Guardian raised the defense that it was the claims fiduciary of the ERISA plan, that the allegations of the newly amended complaint contended that Guardian breached its ERISA fiduciary duties, and that each cause of action of the complaint was preempted by ERISA (347-48).

As discussed, the policy provided that a "covered charge" exists from the time a medical service is rendered. During the trial Unibell repeatedly contended that a *claim*, not a charge, was incurred when a medical service was provided. (This contention is contrary to the terms of the ERISA plan). This was the premise for the central trial argument that Guardian did not accurately report the claims paid when it included in the 1991 renewal proposal claims paid during the prior policy year which were for medical services received during the prior and earlier policy years.

Unibell called one expert witness, Alan Rockman, an insurance broker and an attorney. The substance of Mr. Rockman's testimony was contrary to the express terms of the ERISA plan. Mr. Rockman stated that he had thirty years experience in the insurance industry in the design and administration of group health insurance programs. Mr. Rockman testified as follows:

> Q. In general parlance of the insurance industry, is there a common understanding of what it means to say that claims were incurred during a particular period of time?
>
> A. Yes.
>
> Q. And what is that understanding?
>
> A. Incurred means dates of service, that is when either somebody was in the hospital, somebody went to a doctor's office, that is the date of the service, the dates of service.

> Q. If a claim was incurred within a period it means that the date of the service was during that period?
>
> A. That's right, the medical services were rendered to that person in that time period.

(744).

On cross examination Mr. Rockman admitted that, under the plan, a *charge*, not a *claim*, was incurred when a medical service was rendered to an insured person. He acknowledged that such a charge must be submitted to an insurer for a claim to exist (766-67). Nevertheless, as discussed, *infra*, the contract and renewal offer incurred claims interpretation issues were submitted to the jury, and a verdict for Unibell on four state law causes of action, plus punitive damages, was rendered.

Mr. Rockman prepared a chart showing the effect of the "old claims" on the experience of the group for the policy year in question (576a). This chart was the basis for his calculation of Unibell's damage claim (745-57). In addition, in a further direct challenge to Guardian's administration of the ERISA plan, Mr. Rockman testified that, when computing premium rates for the next policy year, Guardian should not have considered any amounts paid during the prior policy year for services received by Unibell insureds during earlier policy years as current experience since, in his view, this would not be a proper basis for determining renewal premiums. (773).[4]

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4. Mr. Sanford Herman, a Vice-President and Actuary of Guardian, testified that approximately $285 million dollars is paid (Cont'd)

Several Unibell officers testified prior to Mr. Rockman. They also disputed the meaning of the ERISA plan. Dr. Herman Turndorf, the President of Unibell, testified that he understood "incurred claims" in the 1991 renewal offer to refer only to claims paid by Guardian for medical services received by covered persons during the prior policy year.

> Q. What was incorrect about saying Guardian had paid $1.1 million in claims in the just ending policy year?
>
> A. Well, incurred claims, it would seem to me meant that for the period September 1st, 1990 to August 31st, 1991 Guardian paid $1.18 million dollars for claims that were done for health care during that period of time.

(466).

Dr. Turndorf testified that Unibell would not have renewed the plan in 1991 and 1992 if he had known of the dates of the medical services paid during the 1990-91 policy year and the fact that Ms. Filler had become Medicare primary (434).

Mr. Richard Schiffer, a Unibell Vice-President, who is a CPA and attorney, testified that Guardian had misled Unibell concerning the "true claims" during the period in question (212-13). Mr. Schiffer also testified that Unibell

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(Cont'd)
annually by Guardian under group health plans for services provided to insureds during earlier years. Mr. Herman explained that Guardian would face financial ruin if unable to consider such amounts when calculating renewal premiums (827-28).

would not have renewed the plan in 1991 if he knew that the $1.1 million in claims in the 1991 renewal letter included $500,000 for medical care received two to three years earlier (104).

Specifically, Mr. Schiffer was referring to Guardian's 1991 payment of $500,000 to NYU Medical Center for medical services rendered in 1988-1989. The NYU hospital bills were paid by Guardian at the request of Unibell. In 1991 Guardian received a claim form signed by Unibell requesting payment of an NYU hospital bill from 1988-89 in the amount of $400,000 (393a). Guardian promptly paid the bill and sent an explanation of benefits form to Unibell stating that such payment had been made (750a). These actions were taken by Guardian as the ERISA claims fiduciary. The request for payment was made by Unibell, the administrator of the plan. The explanation of benefits was sent to Richard Schiffer, the person designated by Unibell to receive plan related correspondence (785a). The fact that the claims related to pre-policy year charges was indicated. At trial, Mr. Schiffer testified that the review of plan related correspondence was delegated to clerical employees (131-32). Unibell then recovered under state law for the alleged failure of Guardian to have provided such information to Unibell!

The assault on Guardian's administration of the ERISA plan continued to the end of the trial. On summation, the attorney for Unibell told the jury that Guardian was "caught red handed passing off hundreds of thousands of dollars of old claims as though they were incurred in the current year . . . ," (1155) adding that it was "outrageous" to include "old claims" in the current claims experience of the insurer (1157). In repetition of the argument of Unibell's expert, the jury was also told that the $1.1 million amount was not a credible number and should not have been included in the renewal letter (1131).

In the charge, the jury was instructed that Guardian made representations of the amount of incurred claims and that they were to decide whether such representations were false or created a false impression (1189-90). The jury was further to determine whether the failure to disclose the age of the claims "created a false impression and misled Unibell . . . ," or whether the incurred claims amounts were accurate, but misleading, absent other disclosures (1190-91). The jury was also charged to determine whether the alleged failure to disclose the Medicare status of Ms. Filler was required to "avoid making a disclosure of the incurred claim figures not misleading" (1189). These instructions were incorporated into the charges given on fraud, constructive fraud (1198-99), negligent misrepresentation (1203-04), unjust enrichment (1207), § 4226 of the New York Insurance Law, which prohibits an insurer from misrepresenting the "terms, benefits or advantages" of a policy (1209), § 349 of the New York General Business Law (unfair business practices) (1209-11), and on the claim for punitive damages (1214-15).

The jury returned a verdict for Unibell on the constructive fraud, negligent misrepresentation, unjust enrichment and Insurance Law § 4226 causes of action. Punitive damages in the amount of $250,000 were awarded based upon the constructive fraud finding (1268-71).

REASONS FOR GRANTING THE WRIT

I.

THE PETITION SHOULD BE GRANTED BECAUSE THE OPINION BELOW CONFLICTS WITH THIS COURT'S PRIOR RULINGS ON SEVERAL ASPECTS OF ERISA.

A. This Action "Relates To" An ERISA Plan

The New York Supreme Court, Appellate Division, First Department was presented with numerous ERISA related issues which were disposed of by a complete misapplication of fundamental principles declared by this Court.

29 U.S.C. § 1144(a) provides for preemption of state laws that "relate to" an ERISA plan. Prior to *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company*, 514 U.S. 645 (1995), the scope of "relate to" was somewhat uncertain. Some courts had declared that any issues concerning an ERISA plan necessarily "relate to" the plan. Other courts had taken a more restrictive view of the term. In *Blue Cross* this Court adopted a pragmatic and functional approach and declared that "[t]he basic thrust of the preemption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 657. Any state laws which impede that goal "relate to" a plan for preemption purposes. *Id.* at 657-660.

As discussed, the Unibell ERISA plan gave Guardian the discretionary authority to "determine eligibility for benefits and to construe the terms of the plan with respect to

claims" (680a). In 1991 Guardian received claims for Greta Filler for medical services provided to her between 1988-1990. Unibell, the plan administrator, requested that payment be made (393a). The claims were payable under the terms of the ERISA plan. Guardian promptly paid the claims as the ERISA fiduciary and gave Unibell notice of payment (750a). Yet Guardian was found liable for damages on several state law causes of action, plus punitive damages, for including these amounts in the claims for that policy year as reported in the annual renewal proposal.

The basis for this liability was the false contention that Guardian passed off "old claims" as current payments. Yet, these were not "old claims" under the ERISA plan.

The essence of the plaintiff's action involved a challenge to the terms of the ERISA plan and Guardian's obligations under that plan. The ERISA plan obligated Guardian to pay the claims in question and did not require reporting by dates of service. Consequently, the inclusion of those claims in the amount of incurred claims for the prior policy year is consistent with the plan. Any state law challenge to the payment or reporting "relates to" the plan since it, in essence, challenges Guardian's administration of the plan when viewed in the light of the ERISA pleading rules. The well pleaded complaint rule does not apply to ERISA. Thus a state court complaint, purporting to allege state law issues, will be preempted if it encroaches on an area of exclusive federal concern, such as challenges to acts which constitute the administration of ERISA plans or have an adverse financial impact upon such plans. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987).

Could any action have a greater impact on the administration of ERISA plans than state court

misconstructions of such plans, resulting in the award of damages for acts performed in compliance with a plan and the imposition upon ERISA fiduciaries of duties inconsistent with the terms of a plan?

Guardian accurately reported its proper ERISA claims fiduciary activities in the 1991 renewal proposal. Any disputes concerning such acts which have the potential to impede the uniform national administration of ERISA plans "relate to" such plans and must be preempted.

Moreover, the solvency of ERISA plans requires adequate planholder contributions. Any challenges to the renewal premium calculation practices of an insurer must be deemed to "relate to" a plan for the same reasons.

B. *Varity Corp v. Howe* Expanded The Concepts Of ERISA Plan Administration And Fiduciary Duties

Guardian was the ERISA claims fiduciary. The state court opinions held that none of the policy renewal allegations of Unibell constituted a claim for ERISA fiduciary breach because Guardian was found to have been acting as a seller of insurance, not as a claims fiduciary, at those times.

In *Varity Corp. v. Howe*, 516 U.S. 489 (1996), this Court expanded the circumstances under which an ERISA fiduciary acts in that capacity. The acts at issue in *Varity* involved representations by the petitioner, an ERISA plan administrator, concerning a subsidiary, where the representations were made to induce respondents to transfer their employment and their pensions to the subsidiary. The issue was whether ERISA fiduciary obligations are limited

solely to acts of plan administration performed as a fiduciary or whether the duties of an ERISA fiduciary are broader in scope. Varity claimed it was acting as an employer, not as an ERISA fiduciary, when it spoke and that none of the representations related to Varity's administration of the ERISA plan. *Id.* at 495.

This Court incorporated the general duties of trustees into ERISA. Varity was found to have acted in a fiduciary capacity when it made the representations while exercising "such powers as are necessary or appropriate for the carrying out the purposes" of the plan, including "[c]onveying information about the likely future of plan benefits, thereby permitting beneficiaries to make an informed choice about continued participation" in the plan. *Id.* at 502. This Court accepted the factual finding that Varity intentionally misrepresented to its employees that the entity to which they were requested to transfer their employment was financially stable and, thus, their ERISA benefits under the new plan would be secure. "And we hold that making intentional representations about the future of plan benefits in that context is an act of plan administration." *Id.* at 505.

In the present matter, Guardian is alleged to have induced Unibell to renew the plan in 1991 "by misrepresenting the extent of GUARDIAN's risk under a group health insurance plan issued by GUARDIAN, of the employees of UNIBELL." "Guardian's risk" under the plan was the amount of claims it would have to pay as an ERISA fiduciary. Unibell's contention that this risk was misrepresented by the inclusion of the "old claims" in the 1991 renewal proposal, thereby inducing Unibell to pay an excessively high premium, constituted allegations of fiduciary breach under *Varity*.

In the present matter, we have a decision of the New York Supreme Court, Appellate Division, which the highest court of New York declined to review. The decision states that Guardian's preemption claim fails "since defendant, at the time of the misrepresentations upon which plaintiff's fraud claim is premised, was merely engaged in the sale of additional insurance — an activity plainly subject to State regulation, ERISA notwithstanding — and not acting in the capacity of an ERISA claims fiduciary." (App. 2a). This decision, narrowly confining ERISA fiduciary duties only to the described fiduciary status of the entity, flies in the face of *Varity*. It will lead to other misapplications in state court unless reviewed by this Court.[5]

Several United States Courts of Appeals have addressed preemption of ERISA sales related issues. The subject state court decision conflicts with these precedents.

In *Woodworker's Supply Inc. v. Principal Mutual Life Ins. Co.*, 170 F.3d 985 (10th Cir. 1999), the Court analyzed decisions in several circuits on the issue of the preemption of fraudulent inducement claims arising out of the sale of ERISA plans, and concluded that such actions have only been permitted in state court, or in federal courts under state law, when brought against a party that was *not* an ERISA entity at the time the challenged acts were performed. *Id.* at 990-

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5. The reference of the Appellate Division to "defendant's failure to raise the preemption issue as a defense in its answer or in its pretrial motions" is erroneous. The issues related to the "incurred claims" were added to the complaint on the day the trial commenced. Guardian amended its answer to include the ERISA jurisdictional issue. The Appellate Division also failed to consider the non-waivable nature of a subject matter jurisdiction defense based upon complete preemption.

92. These cases included insurers which were not ERISA fiduciaries prior to the sale and insurance brokers who never achieved that status. "Holding insurers accountable for pre-plan fraud does not affect the administration or calculation of benefits, nor does it alter the required duties of plan fiduciaries." *Id.* at 992.

The *Woodworker's* Court noted that fraudulent inducement claims "affecting relations between primary ERISA entities" have been preempted. *Id.* at 990-91. The instant matter deals with the renewal of a plan between such ERISA entities (employer/administrator and claims fiduciary) in which Guardian's administration of the ERISA plan was challenged. Unibell has standing to sue Guardian in federal court for alleged breach of fiduciary duties. 29 U.S.C. § 1132(a)(2). A state court cause of action is preempted if it "conflicts directly with an ERISA cause of action." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142-43 (1990).

C. The Allegations Of Unibell Cannot Be Evaluated Without Reference To The ERISA Plan And Are Consequently Preempted

Rice v. Panchal, 65 F.3d 637, 644 (7th Cir. 1995), *Amended by, Rehearing, en banc, denied by Rice v. Panchal*, 1995 U.S. App. LEXIS 31419 (7th Cir. 1995), discussed several decisions of this Court and observed that "[t]he common thread running through those cases is that complete preemption is required where a state law claim cannot be resolved without an interpretation of the contract governed by federal law." The Court noted that the preemption criteria under the Labor Management Relations Act are applicable to ERISA. *Id.* at 643. *See Allis-Chalmers Corp. v. Lueck*,

471 U.S. 202, 213-14 (1985), in which it was declared that "[w]hile the nature of the state tort is a matter of state law, the question whether the Wisconsin tort is sufficiently independent of federal contract interpretation to avoid preemption, is, of course, a question of federal law."

Guardian was found liable for constructive fraud, negligent misrepresentation, unjust enrichment, violations of New York Insurance Law § 4226 and for punitive damages based upon a theory that was entirely dependent upon a misinterpretation of the ERISA plan. If such actions are not preempted, the goal of uniform administration of ERISA could be subverted through state court allegations of tort or ambiguity-based claims relying upon misinterpretations of ERISA plans. Actions involving the meaning of ERISA plans must be litigated in federal courts where the emerging body of common law applicable to ERISA can be consistently applied. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-111 (1989).

Guardian does business in all fifty states and in the District of Columbia (816). In applicable Labor Management Relations Act precedent, this Court recognized in *Lingle v. Norge Division of Magic Chef, Inc.*, 486 U.S. 399, 405-06 (1988), that state law claims based upon interpretations of contracts governed by federal law must be preempted. Otherwise "there could be as many state-law principles as there are States." *Id.* at 406.

D. The Rule Of Law Upon Which The Judgment Was Based Would Create Financial Havoc For ERISA Plans

This Court has declared that state laws may not create a significant, direct financial impact on ERISA plans. *New York Blue Cross*, *supra*, 514 U.S. at 659-660. Guardian pays approximately 285 million dollars annually for claims for medical services received by insureds during earlier years (827-28). Under the Unibell judgment Guardian is liable for not identifying the claims from earlier policy years in the 1991 renewal proposal. If Guardian is unable to account for these payments in its renewal proposals, it would create financial havoc for ERISA plans.

Moreover, in order to avoid similar results in the future, Guardian would be required to report claims differently in New York than in the rest of the country. This is an impact which state law cannot be allowed to have upon an ERISA plan.

E. The District Court Remand Order Recognized That This Action Was Preempted By ERISA

Guardian removed the action to the United States District Court, Southern District of New York, on the day that leave was granted to add the incurred claims issues to the complaint. The District Court (Hon. John S. Martin, Jr.) remanded the action because "the notice of removal was not timely filed . . ." (974a). Implicit in this determination is a finding that ERISA was implicated and that removal would have been timely if sought within thirty days of the date ERISA issues were first raised by Unibell. Pursuant to 28 U.S.C. § 1446(b), removal must be effected within thirty

days after receipt of the initial pleading, if then removable, or within thirty days after receipt of a copy of an "amended pleading, motion, order or other paper from which it may first be ascertained that the case is one which is or has become removable."

During the argument of the motion, Judge Martin suggested that the original alleged non-disclosure of Ms. Filler's Medicare status issue may also have alleged a fiduciary breach. If this was indeed the Court's belief, then removal two years later would have been considered untimely.

Remand could not confer jurisdiction on the state court for a claim for breach of ERISA fiduciary duties. If removal was untimely, remand was mandatory even if the action was beyond the jurisdiction of the state courts. *See Stack v. Strang*, 191 F.2d 106 (2nd Cir. 1951).

Guardian did not remove the action when it was originally commenced in 1994. Under the law as it then existed, allegations that an ERISA fiduciary intentionally failed to advise a plan that one of the members of the group had become covered by Medicare did not appear to state a claim for fiduciary breach. For the reasons discussed, *infra*, *Varity v. Howe*, decided two years later, changed, or at least clarified, significantly the law in this area.

The jury charge incorporated the Medicare issues into the incurred claims allegations, eliminating any distinction between the two theories. The jury was instructed that Unibell alleges that "Guardian omitted to state in 1991 and 1992 renewal letters that Medicare had become a primary insurer for Greta Filler as of April, 1991. Unibell claims that the

disclosure of this fact was required to avoid making a disclosure of the incurred claim figures not misleading." (1189). Thus, the incurred claims issues as presented to the jury encompassed the Medicare allegations.[6]

II.

THE STATE COURT DECISION MISAPPLIED THE ERISA "SAVINGS CLAUSE".

29 U.S.C. § 1144(b)(2) states that "[e]xcept as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." This is the ERISA "savings clause." Subparagraph (B) contains inapplicable provisions concerning non-insurance based employee benefit plans.

The decision of the Appellate Division cited "*John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99-100; [and] *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727-730" in support of the proposition that the state may regulate the sale of insurance involved in the renewal of an ERISA plan and upheld recovery against Guardian on common law causes of action and a statutory claim which is based upon generally applicable common law principles.

---

6. It should be noted that Guardian, while acting as the ERISA claims fiduciary, sent many documents to Unibell indicating that Ms. Filler was covered by Medicare. *See, e.g.*, 800a-821a. These documents evidence Medicare payments followed by submission of the balances to Guardian for payment. Medicare was thus shown to have been the primary payor.

Both cases cited by the Appellate Division discussed only the ERISA savings clause at the pages referenced.

The Appellate Division decision completely disregarded the basic principle that the savings clause exempts from preemption only state laws which are "limited to entities within the insurance industry." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985). *See also Unum Life Ins. Co. of America v. Ward*, __ U.S. __, 119 S. Ct. 1380, 1386, 143 L. Ed. 2d 462, decided on April 20, 1999.

The decision of the Appellate Division did not distinguish between the common law and statutory claims. All were given the blanket protection of the savings clause.

Constructive fraud, negligent misrepresentation, unjust enrichment, and punitive damages are New York common law causes of action or remedies that apply to everyone and, by definition, cannot be laws regulating insurance because they are not directed at the insurance industry. *Unum Life*, *supra*, 119 S. Ct. at 1386-1388.

Likewise, Insurance Law § 4226 has been held not to fall within the savings clause since it "merely codifies general principles of common law fraud in an attempt to limit unfair trade practices." *DeBruyne v. Equitable Life Assur. Society*, 920 F.2d 457, 469 (7th Cir. 1990).[7]

As recognized in *DeBruyne*, § 4226 provides a rescissionary type remedy for misrepresentations of the

7. New York Insurance Law § 4226(a)(1) prohibits an insurer from misrepresenting the "terms, benefits or advantages" of a policy. Plaintiff recovered the statutory penalty of all premiums paid for the 1991-92 policy year under that statute.

"terms, benefits or advantages" of an insurance policy, based upon common law fraud principles which would be applicable in any other state contract action. *Id.* at 469-470. In *Unum Life*, *supra*, 119 S. Ct. at 1387, this Court held that a state law based upon generally applicable common law principles cannot be a law regulating insurance.

Preemption is also required because a state law cause of action cannot contain a remedy inconsistent with those available under ERISA. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53-56 (1987). § 4226(d) of the New York Insurance Law provides for a super rescissionary penalty since the claims paid by an insurer are not offset against premiums refunded. There is no such remedy available under ERISA. *See* 29 U.S.C. § 1132.

It should also be noted that the alleged misrepresentations which were the basis for recovery under the statute are the same incurred claims arguments shown in Point I to be preempted.

Pilot Life also reiterated that ERISA does not provide for the granting of punitive damages. *Id.* at 53-54 (citing *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985)). Unibell was awarded punitive damages in the amount of $250,000 (1271). The award of punitive damages is an illustration of the consequences of litigating ERISA fiduciary breach actions in state courts.

Sanford Herman, a Vice President and Actuary of Guardian, testified that the underwriters computed the renewal premium offer for the 1991-92 policy year by reviewing the experience of the group for the preceding year. Mr. Herman explained that the premium offered to Unibell,

when adjusted for inflation, discounted the group's experience for the just completed year by approximately 50% (872). The proposed premium for 1991-92 was approximately $700,000 and the claims for 1990-91 had been $1.18 million (132a). Mr. Herman explained that 50% of the experience from the 1990-91 year was not credible, meaning that it was thought unlikely to recur (839-40). The amount discounted equaled the $500,000 NYU Hospital bills.

However, on the post-trial motion to set aside the verdict, the trial court misinterpreted this testimony and concluded that Guardian had defrauded Unibell when it reported the amount of incurred claims for 1990-91.

> There is no doubt that the verdict on the punitive damage claim as well as the constructive fraud are sufficient to show that the jury found a knowing violation of Section 4226. The testimony showed that Guardian believed that its own underwriter had disregarded at least 50% of the amount shown on the renewal letter sent to plaintiff.

(9a).

The explanation of Mr. Herman that Guardian discounted half of the experience as not likely to recur, and reduced the premium requested accordingly, was distorted into a misstatement that Guardian presented a number in the ERISA renewal proposal that it didn't believe was accurate.

In reality, the renewal offer correctly stated the amount of incurred claims as a historical fact (132a). There was no misrepresentation as a matter of law. But even if there were a question in this regard, it would be an issue which only a federal court has the jurisdiction to address.

CONCLUSION

The magnitude of the incursion of the state courts into exclusive federal ERISA jurisdiction, which occurred in this action, is unprecedented. Review by this Court is of exceptional importance to ERISA jurisprudence.

Respectfully submitted,

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APPENDIX

APPENDIX A — JUDGMENT OF THE SUPREME COURT OF NEW YORK FOR THE APPELLATE DIVISION, FIRST DEPARTMENT DATED AND ENTERED DECEMBER 29, 1998

Lerner, P.J., Wallach, Tom, Andrias, JJ.

3224

Unibell Anesthesia, P.C.,

Plaintiff-Respondent,

Steven E. Obus

– against –

The Guardian Life Insurance Company of America,

Defendant-Appellant.

Robert D. Meade

Judgment, Supreme Court, New York County (Lewis Friedman, J.), entered October 30, 1997, which, upon a jury verdict in plaintiff's favor, awarded plaintiff $746,000 in compensatory damages and $250,000 in punitive damages, as well as a statutory penalty of $805,719 pursuant to Insurance Law § 4226(d), plus interest, costs and disbursements, for a total amount of $2,176,152.56, and bringing up for review an order of the same court and Justice, entered October 23, 1997, *inter alia*, denying defendant's motion to set aside the verdict on the ground that the court

lacked subject matter jurisdiction or as against the weight of the evidence, unanimously affirmed, with costs.

The jury's finding in plaintiff's favor on its causes of action for constructive fraud, negligent misrepresentation, unjust enrichment and violation of Insurance Law § 4226 was amply supported by the evidence showing that misrepresentations and omissions by defendant insurance company had induced plaintiff to pay exorbitant premiums for its group health coverage for policy years 1991 and 1992. The proof, also supported the jury's awards of damages, both the punitive and compensatory, in the above amounts.

In addition to challenging the verdict as against the weight of the evidence, defendant contends that the subject action is preempted by the Federal Employee Retirement Security Act ("ERISA") (29 USC § 1001, *et seq.*). However, even if it were appropriate to disregard defendant's failure to raise the preemption issue as a defense in its answer or in its pretrial motions, defendant's preemption claim would still fail since defendant, at the time of the misrepresentations upon which plaintiff's fraud claim is premised, was merely engaged in the sale of additional insurance — an activity plainly subject to State regulation, ERISA notwithstanding — and not acting in the capacity of an ERISA claims fiduciary (*see*, *John Hancock Mut. Life Ins. Co. v Harris Trust & Sav. Bank*, 510 US 86, 99-100; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 US 724, 727-730).

We have considered defendant's remaining arguments and find them to be unpersuasive.

Appendix A

THIS CONSTITUTES THE DECISION AND ORDER
OF THE SUPREME COURT, APPELLATE DIVISION,
FIRST DEPARTMENT.

ENTERED: DECEMBER 29, 1998

s/ [illegible]
CLERK

APPENDIX B — ORDER OF THE SUPREME COURT OF THE STATE OF NEW YORK FOR THE COUNTY OF NEW YORK, IAS PART 11 DATED OCTOBER 20, 1997 AND FILED OCTOBER 23, 1997

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: IAS PART 11

Index No. 129025/94
Seq. No. 009

UNIBELL ANESTHESIA, P.C.,

Plaintiff,

– against –

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA and PETER PECK,

Defendants.

LEWIS R. FRIEDMAN, Justice

Defendant Guardian moves to set aside the jury verdict entered against it in this case and for a dismissal of the complaint, on the ground that the court lacked subject matter jurisdiction, or for a new trial, on the ground that the verdict was against the weight of the evidence. Plaintiff cross moves for the court to set the amount of pre-verdict interest.

The court will not repeat the facts that have been set forth at length in the various pre-trial and appellate proceedings and the evidence at trial. Suffice it to note that

the jury found defendants liable for constructive fraud, negligent misrepresentation, unjust enrichment and a violation of Insurance Law § 4226 with respect to the 1991 renewal letter. The jury found in defendant's favor on the question of actual fraud, whether there was a violation of General Business Law § 349, and whether there was a violation of Insurance Law § 4226 with respect to the 1992 renewal letter. The jury found compensatory damages of $746,000 and awarded punitive damages of $250,000. The amount of the damages to be awarded pursuant to Insurance Law § 4226 was not submitted to the jury since, as the court and counsel agreed, there was a stipulated amount of damages, the premiums that had been paid and there was no issue of fact on that item.

Defendants' primary argument is that the entire action was preempted as a matter of federal law by ERISA. That issue was not made in the pretrial motions or on the prior appeal to the Appellate Division; it was brought up for the first time on the day set for the beginning of the trial. On that day, defendant removed the action to federal court. This court retained the jury and awaited the not unexpected remand the next day. In simple terms the argument made on this motion and on the motion at the beginning of the trial is that the claims made by plaintiff are essentially being brought against defendant Guardian, which is a "claims fiduciary." Therefore Guardian contends that it is subject to suit under ERISA solely in federal court and that the state common law causes of action are preempted (29 USC § 1144[a]).

In the pretrial motion defendant relied on the March 26, 1996 decision by Judge Jones in the United States District

Court for the Southern District of New York in ***Raff v Travelers Ins. Co.***, 90 Civ 7673. This court had previously noted that ***Raff*** appeared to be inconsistent with Second Circuit authority. Defendant on this motion discloses that in a decision filed May 26, 1997, more than one month before the trial of this case started, Judge Jones disclosed that relying on the recent Second Circuit authority she had *sua sponte* reconsidered the preemption question and directed that the case be tried both on ERISA grounds and the state law ground. The May decision found that the state law claims were not preempted by ERISA since the action did not involve "an action by an employee to collect benefits and it does not effect how benefits are calculated or paid. In fact, plaintiff's claims neither seek to enforce nor relate to the regulation or administration of any covered plan." The recent decision, which had not been made available to this court prior to a ruling based on the long out dated and recalled 1996 decision, is consistent with ***Geller v County Line Auto Sales, Inc.***, 86 F3d 18 [2d Cir. 1996], and other authorities which have made it clear that there is no preemption for matters that have "an indirect economic effect on choices made by insurance buyers, including ERISA plans" (***NYS Health Maintenance Org. Conference v Curiale***, 64 F3d 794, 803 [2d Cir. 1995]).

The majority of defendant's argument is based on its notion that the case is about how it reports its claims incurred or potential claims. The simple fact in this case is that plaintiff asserted that the method in which defendant sought renewals of the insurance policy was fraudulent and misleading. The causes of action relate to defendant's efforts to enter into a different contract with plaintiff than the one

that was expiring. There is nothing in any of the ERISA cases that precludes a fraud action based on statements made to the proposed insured. The court notes that there is no ERISA requirement that defendant submit any claims data in its request for a renewal policy. The decision to include claims data is one that Guardian chose for itself and this action related to the inadequacy and misleading nature of that data. It did not impact required reporting or the payment of any of the claims.

The fact that Guardian was a claims fiduciary had nothing whatever to do with the representations it made in attempting to sell additional insurance for the following year. The Supreme Court has made it clear that an expansive reading of whether a claims is "related to" an ERISA plan is not appropriate (***De Buono v. NYSA-ILA Medical & Clinical Services Fund***, 117 S Ct 1747; ***California Div. of Labor Stds. Enforcement v Dillingham Construction NA, Inc.***, 117 S Ct 832). The claim against defendant was simply not in its role as a claims fiduciary (***see Andujar v. Lenox Hill Hosp.***, 226 AD2d 179, 180).

Guardian itself notes that the standard for retention of state actions in the Second Circuit is more favorable than in some other circuits (reply memo. p.5). Pursuant to ***Geller*** even if there were a "tangential" impact on the plan's administration there is no basis for preemption. Thus Guardian's belated claim of ERISA preemption fares no better when made after trial than it did during jury selection. The court finds that there was proper subject matter jurisdiction in this court.

Appendix B

Defendant attacks the court's instruction with respect to the definition of "misleading." The court's review of the charge as given does not support the contention that the jury were incorrectly charged. There was a question for the jury whether the statements as given were misleading, even if literally true. The charge requested by Guardian would have confused the concepts of mental state and whether half-truths were given.

Defendant contends that the proof was inadequate to support a finding of punitive damages. The jury found a constructive fraud based on instructions that incorporated the elements set forth in ***Rocanova v Equitable Life Assurance Society***, 83 NY2d 603. To the extent that defendant contends that the verdict is inconsistent the claim is presented too late. Well established law holds that any claim of inconsistency in a verdict is waived unless the claim is presented before the discharge of the jury (***see, e.g., Grzesiak v General Electric Co.***, 68 NY2d 937, 939; ***Barry v Manglass***, 55 NY2d 803, 805-6; ***Echavarria v Cromwell Assocs.***, 232 AD2d 347). The court notes that the proof, considered in the light most favorable to plaintiff, the winning side, supports a finding that the conduct alleged, the "disclosure" of misleading information, on standard forms that were sent to over 10,000 policy holders, where the employees did not have the authority to conform the form to the facts of the case, was sufficient to support a finding of willful and wanton conduct aimed at the public at large. Even if the issue were preserved for review on this post-trial motion to set aside the verdict, the court finds no inconsistency with a finding of no actual intent to commit fraud with the finding of willful, malicious conduct. This case is a far cry from

Appendix B

Sobie v Katz Construction Corp., 189 AD2d 49, 53, where the finding of maliciousness was clearly inconsistent with a finding of no culpable conduct and a zero percentage of fault. Here the jury found a constructive fraud, unjust enrichment and negligent misrepresentation. Any inconsistency could have been resolved before the jury was disbanded, but defendant waived the claim during the trial. It is too late to attempt to preserve the issue at this time. The court does not find the award of punitive damages to be against the weight of the credible evidence.

Finally defendant argues that the penalty required by Insurance Law § 4226 should not be imposed because the charge failed to include the element of a knowing violation. Suffice it to note that defendant did not, when given the opportunity after the charge, call the matter to the court's attention (***Bichler v Eli Lilly & Co.***, 55 NY2d 571, 583, *overruled on other grounds sub nom.* ***Kaufman v Eli Lilly & Co.*** 73 NY2d 487). On the instant motion defendant argues that since the charge as given was correct to have the jury determine whether there was a violation of the statute, there was no requirement that the issue of whether the penalty would attach for a knowing violation was a failure by plaintiff to request a corrective instruction. The court is not persuaded by defendant's argument. The issue had always been whether the statements given by defendant to plaintiff was a "term, benefit or advantage" within the meaning of the statute. Thus the knowledge question was not discussed by the parties. The cases have held that where there is a failure to bring to the court's attention that an element of a cause of action was not included in the charge, there is a waiver of the claim (***e.g. DeLong v County of Erie,*** 60 NY2d 296, 306; ***Pogo***

Appendix B

Holding Corp. v New York Prop. Ins. Underwriting Assn, 62 NY2d 969, 971).

The court is convinced that there is ample evidence to establish that if, as the jury found, there was a violation of the statute, the violation was knowing. Indeed, the instructions taken as a whole establish that the jury was advised that in order to find a constructive fraud it had to find "that Guardian knew that Unibell was acting under a mistaken belief that Guardian was primary for Greta Filler" and that the jury had to find that "Guardian had notice that Unibell was acting under a mistaken belief that Guardian was primary for Greta Filler's claims." There is no doubt that the verdict on the punitive damage claim as well as the constructive fraud are sufficient to show that the jury found a knowing violation of Section 4226. The testimony showed that Guardian believed that its own underwriter had disregarded at least 50% of the amount shown on the renewal letter sent to plaintiff.

In simple terms the court finds no basis to set aside the verdict or to grant judgment for defendant. Defendant's motion is denied in all respects.

Plaintiff's motion for pre-verdict interest appears to state the law and the facts correctly. There is no reason to deny the application.

The judgment should include interest on the fraud claim in the sum of $315,466.48. Additionally the jury verdict should be supplemented by the addition of $805,719 for the Third Cause of action, as the penalty for a violation of

Appendix B

Insurance Law, Section 4226, since that appears to represent the premiums paid for the 1991 policy year.

The Clerk shall enter judgment in essentially the form annexed as Exhibit A to plaintiff's Notice of Cross Motion.

This shall constitute the decision and order of the court.

Dated: October 20, 1997

s/ [illegible]
J.S.C.

APPENDIX C — ORDER OF THE SUPREME COURT OF NEW YORK FOR THE APPELLATE DIVISION, FIRST DEPARTMENT DENYING REARGUMENT AND/OR LEAVE TO APPEAL TO THE COURT OF APPEALS DATED FEBRUARY 11, 1999

At a Term of the Appellate Division of the Supreme Court held in and for the First Judicial Department in the County of New York, on February 11, 1999

Present - Hon. Richard W. Wallach, Justice Presiding,
Alfred D. Lerner
Peter Tom
Richard T. Andrias, Justices.

M-236
Index No. 129025/94

Unibell Anesthesia, P.C.,

Plaintiff-Respondent,

-against-

The Guardian Life Insurance Company of America,

Defendant-Appellant.

Defendant-appellant having moved for reargument of, or in the alternative, for leave to appeal to the Court of Appeals from, the decision and order of this Court entered on December 29, 1998 (Appeal No. 3224),

Appendix C

Now, upon reading and filing the papers with respect to the motion, and due deliberation having been had thereon,

It is ordered that the motion be and the same hereby is denied in its entirety, with $100 costs.

ENTER:

s/ Catherine O'Hagan Wolfe
Clerk.

APPENDIX D — ORDER OF THE COURT OF APPEALS OF THE STATE OF NEW YORK DENYING MOTION FOR LEAVE TO APPEAL DATED MAY 13, 1999

State of New York,
Court of Appeals

At a session of the Court, held at Court of Appeals Hall in the City of Albany on the thirteenth ***day of*** May 1999

Present, HON. JOSEPH W BELLACOSA, *Senior Associate Judge, presiding.*

1-10 Mo. No. 291

Unibell Anesthesia, P.C.,

Respondent,

v.

The Guardian Life Insurance Company of America,

Appellant.

A motion for leave to appeal to the Court of Appeals in the above cause having heretofore been made upon the part of the appellant herein and papers having been submitted thereon and due deliberation having been thereupon had, it is

Appendix D

ORDERED, that the said motion, insofar as it seeks leave to appeal from the Appellate Division order denying appellant's motion for reargument or, in the alternative, leave to appeal to this Court, be and the same hereby is dismissed upon the ground that such order does not finally determine the action within the meaning of the Constitution; and it is

ORDERED, that the said motion for leave to appeal otherwise be and the same hereby is denied. Chief Judge Kaye took no part.

s/ Stuart M. Cohen
Stuart M. Cohen
Clerk of the Court

APPENDIX E — RELEVANT STATUTES AND LAW

29 U.S.C. § 1132(a) and (e)

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought —

(1) by a participant or beneficiary —

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (*l*) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged

violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

* * *

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

* * *

Appendix E

29 U.S.C. § 1144(a)

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

* * *

New York Insurance Law § 4226(a)(1) and (d)

§ 4226. Misrepresentations, misleading statements and incomplete comparisons by insurers

(a) No insurer authorized to do in this state the business of life, or accident and health insurance, or to make annuity contracts shall:

(1) issue or circulate, or cause or permit to be issued or circulated on its behalf, any illustration, circular, statement or memorandum misrepresenting the terms, benefits or advantages of any of its policies or contracts;

* * *

(d) Any such insurer that knowingly violates any provision of this section, or knowingly receives any premium or other compensation in consequence of such violation shall, in addition to any other penalty provided in this chapter, be liable to a penalty in the amount of such premium or compensation, which penalty may be sued for and recovered by any person aggrieved for his own use and benefit, in accordance with the provisions of the civil practice law and rules.

* * * *

Supreme Court, U.S.
FILED
SEP 8 1999
OFFICE OF THE CLERK

No. 99-249

IN THE
Supreme Court of the United States

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA,

Petitioner,

v.

UNIBELL ANESTHESIA, P.C.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF NEW YORK, APPELLATE DIVISION, FIRST DEPARTMENT

RESPONDENT'S BRIEF IN OPPOSITION

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PARTIES AND RULE 29.6 STATEMENT

The petition accurately lists the parties to the proceeding.

There is no parent or publicly held company owning 10% or more of the stock of respondent Unibell Anesthesia, P.C.

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COUNTERSTATEMENT OF THE CASE

Respondent Unibell Anesthesia, P.C. ("Unibell"), respectfully submits this brief in opposition to the petition for a writ of *certiorari* to the Supreme Court of the State of New York, Appellate Division, First Department, of petitioner The Guardian Life Insurance Company of America ("Guardian").

1. Introduction

This case arises from a series of misrepresentations made by Guardian in order to induce Unibell to purchase, and to pay exorbitant premiums for, the group health insurance policies covering Unibell's employees that Unibell purchased from Guardian in 1991 and 1992. The misrepresentations concerned the costs of medical care for one of Unibell's employees, a nurse-anesthetist named Greta Filler.

In late 1988, Ms. Filler suffered a catastrophic illness, a brain tumor with serious post-surgical complications, that resulted in a three-year hospital stay. Following the onset of Ms. Filler's condition, Guardian increased Unibell's annual premiums from approximately two hundred seventy thousand dollars in 1989 to nearly one million dollars in 1992. Unibell proved that Guardian misled Unibell into paying these exorbitant premiums by painting a misleading picture of massive looming expenditures for Ms. Filler's care at a time when Guardian knew, but Unibell did not, that Guardian's risk with respect to Ms. Filler had in fact dramatically declined.

To induce Unibell to pay these excessive premiums, Guardian:

(i) concealed that the federal Medicare program had become the primary insurer for Ms. Filler as of 1991 — coverage that Guardian was "instrumental" in procuring, but about which it did not advise Unibell until 1993, an "error" for which Guardian later "apologized";

(ii) cited in its renewal notice for the Unibell policy in 1991 a figure of $1,118,000 for claims "incurred" during the prior year as justification for an increase in Unibell's annual premium; in fact, the $1.1 million in "incurred" claims included over $500,000 in bills for Ms. Filler's care that dated back two or more years; and

(iii) in its renewal letter for 1992, told Unibell that it had "no recourse" but to increase its premiums yet again (by an additional $250,000) and then confirmed to Unibell's insurance broker that this was due to the "large, ongoing" claims incurred, when the incurred claims had in fact precipitously declined, as had Guardian's prospective risk, because of Ms. Filler's undisclosed Medicare-primary status.

After five days of trial — interrupted during its first day by Guardian's frivolous removal of this then two-and-a-half-year-old action to the United States District Court for the Southern District of New York, followed by an immediate remand — and a day of deliberation, the jury returned a verdict for Unibell on its causes of action for constructive fraud, negligent misrepresentation, unjust enrichment and a violation of New York's Insurance Law section 4226, which prohibits an insurer from selling its policies by

misrepresenting their "terms, benefits or advantages." The Supreme Court of the State of New York, New York County, entered judgment for Unibell in the total amount of $2,175,132.56. (R 11a-12a.)[1]

Guardian took two appeals in this matter, one from the order of the trial court denying Guardian's pre-trial motion for summary judgment, and a second from the trial court's order denying Guardian's motion to set aside the verdict. On each occasion, the Appellate Division unanimously affirmed and declined to grant permission for a further appeal to the New York Court of Appeals.

Guardian's petition for a writ of *certiorari* to the Appellate Division seeks review of its contention, raised for the first time more than two years after the commencement of this action, that Unibell's state law claims arising from Guardian's deceptive insurance sales practices are preempted by the Employee Retirement Income Security Act of 1974, commonly known as ERISA. The position advanced by Guardian has been uniformly and repeatedly rejected by numerous federal and state courts, applying principles of federal law that have been definitively determined by this Court. Guardian has failed to identify any compelling reason for the issuance of a writ of *certiorari*, nor has it made even a colorable showing that the disposition of this matter by the courts of the State of New York was inconsistent in any respect with federal law. Accordingly, Guardian's petition should be denied.

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1. References to pages of the record on appeal to the Supreme Court of the State of New York, Appellate Division, First Department, filed by Guardian, are cited as "R __." References to the petition for a writ of *certiorari* filed by Guardian are cited as "Pet. at __."

2. Unibell's Purchase Of Group Health Insurance From Guardian

Unibell is a professional corporation that provides anesthesiology services to patients at New York University Medical Center and Bellevue Hospital, in addition to training residents at those teaching hospitals and performing medical research. (R 78-79, 412-13.) The president of Unibell is Dr. Herman Turndorf, who is also the chairman of the department of anesthesiology at the NYU Medical Center and a professor of anesthesiology at the NYU School of Medicine. (R 78, 410-11.)

Unibell first purchased a group health insurance policy from Guardian in 1975 or 1976. (R 260.) The Guardian policy was renewable annually, for one-year periods only. (R 261.) Each October, Unibell would receive a letter from Guardian that would advise Unibell of the proposed premium for the coming year.

3. Greta Filler's Catastrophic Illness

In approximately September 1988, one of Unibell's employees, a nurse-anesthetist named Greta Filler, underwent a sixteen-hour surgery to remove a brain tumor, which resulted in her becoming severely disabled. Ms. Filler spent the next three years in the hospital, or in the Rusk Institute for Rehabilitative Medicine. (R 417.) After she was discharged from the Rusk Institute in 1991, Ms. Filler returned home, where she required the assistance of a home health care aide or a nurse. (R 889.)

4. The 1991 And 1992 Renewals

Until the events at issue, the format of Guardian's renewal proposals varied little from year to year, and did not refer at all to Unibell's prior claims history. (R 83-84, 130a.) In its annual premium proposal dated October 14, 1991, however, Guardian deviated from its letters of prior years, and recounted that Guardian had "incurred claims" in the prior year in an amount exceeding $1.1 million. (R 132a-33a.) Noting that Guardian's premium rates were established pursuant to an "experience rating plan" and that Unibell's loss ratio for the prior year was "significantly above average," Guardian advised that it must increase Unibell's rates. (R 132a.) A seventy-five percent premium increase — to approximately $700,000 — was proposed. (R 89-90, 424.)

Although Dr. Turndorf was unhappy about the dramatically increased premium, he believed that Unibell had no choice but to pay it because he felt a moral obligation to provide continued health care coverage for Ms. Filler, and saw no alternative. (R 90.)

Guardian's annual letter to Unibell, dated October 13, 1992, omitted the section of its prior letter that compared premiums to claims incurred. Rather, Guardian reported that, notwithstanding the prior year's dramatic increase, it was again left with "no recourse but to increase your Health Insurance rates in the coming year." (R 134a-135a, 92-93, 226.) This predictably left Unibell with the impression that Guardian was continuing to incur claims at least at the level of the year before, because Ms. Filler's condition had stabilized. (R 217-18, 427-29.) Unibell's broker, who was asked by Unibell to contact Guardian to determine the reason for the premium increase, confirmed this impression. (R 214-

16.) The broker reported back that Guardian had represented that it was raising the premiums once again because of "the same ongoing claim" that had caused Guardian to raise the rates in the prior year — *i.e.*, the claim of Ms. Filler. (R 277-78.) Guardian increased Unibell's premium to approximately $943,000. (R 92, 640.)

5. Guardian Discloses That Medicare Was The Primary Insurer For Ms. Filler

In early 1993, Unibell's office manager became "puzzled" when he discovered certain forms that indicated that Medicare had paid some of Ms. Filler's bills. (R 312-13.) At his request, Unibell's bookkeeper questioned Guardian about this. Approximately one week later, Unibell received a letter from Guardian, dated March 15, 1993, which acknowledged for the first time that, for the prior two years, Medicare, not Guardian, had been primarily responsible for paying for Ms. Filler's care. The letter apologized for "any inconvenience our error may have caused you regarding the proper order of benefits." (R 129a.) Unibell's office manager did not know prior to the receipt of this letter in March 1993 that Medicare was the primary insurer for Greta Filler's claims. (R 314-15.) Neither did Unibell's vice president (R 93-95) or Dr. Turndorf (R 432-33), or Unibell's insurance broker. (R 276.)

Guardian did, however, know that Ms. Filler was Medicare-primary — its claims department was "instrumental in getting her on Medicare." (R 567-68, 274a.) Guardian's underwriting department, which was responsible for determining Unibell's renewal premiums and generating the annual renewal letters, was also aware that Ms. Filler was Medicare-primary. (R 565-66, 270a-72a; *see also* R 784a.)

Dr. Turndorf testified that, when he learned of the letter in which Guardian finally disclosed that Ms. Filler was Medicare-primary, he was "confused" because of the inconsistency between that fact and Guardian's earlier representations of very large ongoing incurred claims for Ms. Filler. (R 432-33.) Dr. Turndorf also testified that if he had known in 1991 that Medicare was the primary insurer for Greta Filler's claims, Unibell would not have renewed the Guardian policy on the terms proposed. (R 433.)

6. Guardian's Misleading Statements Concerning "Incurred Claims"

Unibell alleged in its original complaint, filed in October 1994, that Guardian had fraudulently overstated its risk in inducing Unibell to renew. The focus of that complaint was Guardian's failure to disclose that Medicare had become the primary payor for the claims of Greta Filler. It became apparent during discovery, however, that Guardian had also obscured Ms. Filler's Medicare status in another way. (*See* R 64a-68a.)

Unibell learned that the $1.1 million figure cited by Guardian in its 1991 renewal letter actually included claims for services rendered to Greta Filler in 1988, 1989, 1990 and 1991. (R 628-29.) Of the total of over $1,118,000, more than $500,000 related to two claims for Greta Filler's care that dated back as far as 1988. (R 622-27.) Those claims would have been Guardian's obligation even if Unibell had not renewed in 1989 or 1990. (R 744-45.)

When Unibell received the 1991 renewal letter, Dr. Turndorf and other Unibell personnel believed that the "incurred claims" figure represented "the cost of care

provided to all Unibell employees, including Greta Filler, during the time period referenced in the letter of September 1, 1990 to August 31 of '91." (R 91, *see also* R 487-88, 494, 496-97.) Unibell also presented the expert testimony of a consultant and broker in the field of group insurance plans with over thirty years experience in the insurance industry (R 724-25), who confirmed that Dr. Turndorf's understanding of "incurred claims" is in fact the common understanding in the insurance industry — a claim is "incurred" within a particular period if the service for which coverage is sought was provided during that period. (R 744.)

In sum, in the October 1991 letter, Guardian advised Unibell that it had "incurred claims" of over $1.1 million during the preceding twelve months when in fact most of those claims had been incurred prior to that period. Moreover, if Greta Filler were to need further hospitalization, her claims would be the primary responsibility of Medicare, a fact known to Guardian, but which Guardian never told Unibell. Indeed, of the more than $870,000 in claims for Greta Filler that were included in the $1.1 million total, not one was incurred after April 1, 1991, the date on which she became Medicare-primary. (R 627-28.)

Guardian's renewal underwriters had all of this information and concluded that the following year's claims would not be anywhere near as high as $1.1 million — they in effect "discarded" over half that amount as having no predictive value for the following year's claims. (R 871-73.) Nevertheless, Guardian included the full $1.1 million figure in the renewal letter, without any attempt to explain the origins or the limitations of that misleading number. This grossly inflated number was included in the letter to persuade Unibell to renew, despite the fact that it was being asked to pay a 75% higher premium. (R 879-82.)

When Unibell finally learned that Ms. Filler was Medicare-primary, it was able to leave Ms. Filler off of the plan, without impairing her ability to receive the health care she needed, and to purchase insurance from a different company. (R 102-03, 429-31.) As a result, Unibell saved nearly $800,000 in a single year. (R 103.)

7. Proceedings Below

Unibell commenced this action in the Supreme Court of the State of New York in October 1994, asserting causes of action for (i) fraud; (ii) constructive fraud; (iii) negligent misrepresentation; (iv) violation of section 4226 of New York's Insurance Law, which prohibits an insurance company from misrepresenting the "terms, benefits or advantages" of its policies; (v) violation of section 349 of New York's General Business Law, which prohibits unfair and deceptive trade practices; and (vi) unjust enrichment. (R 16a-31a.)

In October 1996, at the conclusion of discovery, Guardian moved for summary judgment. The Supreme Court denied Guardian's motion by decision dated January 13, 1997 (R 83a-90a), relying, in part, on the evidence concerning the incurred claims, and concluding that Unibell had adduced more than sufficient evidence to support all of its causes of action. (R 84a-86a.)

Guardian appealed from the denial of its summary judgment motion and, on May 15, 1997, the Appellate Division, First Department, unanimously affirmed the lower court's decision. (R 91a-92a.) On July 3, 1997, the Appellate Division denied Guardian's motion for an order granting reargument, or, in the alternative, granting leave to appeal

to the New York Court of Appeals. (RA 11.) At no time during the briefing or argument of Guardian's summary judgment motion, its appeal of the denial of that motion, or its motion for leave to reargue or appeal to the Court of Appeals, did Guardian contend that the evidence concerning the incurred claims ought not be considered, or that this action was in any respect preempted by ERISA.

It was not until shortly before trial, two and one-half years after this action was commenced, that Guardian first raised the contention that it presses on this petition for *certiorari* — that this action is preempted by ERISA. Guardian moved by order to show cause, returnable the morning the trial was scheduled to begin, to preclude Unibell from offering any evidence that Guardian had misrepresented Unibell's "incurred claims" in its renewal letters, on the ground that such allegations were preempted by ERISA, and because Unibell had not explicitly alleged in its Amended Complaint that the "incurred claims" figures were false or misleading. (R 34a-39a.) Unibell opposed the motion, pointing out that it had contended from the outset that Guardian had fraudulently overstated its risk in insuring Unibell's employees,[2] and that the supporting evidence concerning incurred claims had been central to Unibell's arguments both in opposition to Guardian's summary judgment motion, and on appeal from the denial of that motion. Unibell also protectively cross-moved to amend its Amended Complaint to add a single paragraph describing this evidence. (R 60a-62a.)

2. In fact, the language concerning overstatement of risk that Guardian incorrectly claims was added on the first day of trial (*see* Pet. at 4-5) appeared in Unibell's original Complaint, filed in October *1994* and in its Amended Complaint, filed in March 1995, over two years before the trial started. (*See* R 17a, 64a.)

In a decision rendered on the record before the jury was seated, the trial court denied Guardian's motion to preclude Unibell's evidence and granted Unibell's cross-motion to amend the complaint. (R 14a, 5-12.) The court rejected Guardian's claim that it would suffer prejudice from the presentation of the "incurred claims" evidence, explaining:

> [T]he nature of the proof the plaintiff seeks to offer and the nature of the claims have been in this case for some time — some time being at least prior to the making of the motion for summary judgment. . . . It involved issues that were before the Appellate Division and matters that were briefed in that Court in the appeal which was recently decided by that Court. I don't see any surprise or change of legal theory involved in what plaintiff seeks to do.

(R 6-7.)

The court also rejected Guardian's assertion that Unibell's claims concerning the fraudulent nature of the "incurred claims" figures in Guardian's renewal letters were preempted by ERISA. (R 7-12.) The court recognized that allegations of fraud against an insurer acting as a seller of insurance are not preempted by ERISA merely because the insurer happens also to be, in another capacity, an ERISA fiduciary. (R 8.) Finally, the court observed that Guardian's motion to preclude Unibell's evidence "was intentionally made at the last minute in an effort to delay this trial and borders on bad faith." (R 12.)

Having had no success in persuading the state courts that Unibell's claims should be dismissed, Guardian made

one last attempt to avoid trial. Upon returning from the lunch recess on the first day of trial, Unibell learned that Guardian had removed the action to the United States District Court for the Southern District of New York, more than two-and-a-half years after the commencement of this action. (R 972a-73a.) Upon Unibell's motion by order to show cause served that same afternoon, the Honorable John S. Martin, Jr., U.S.D.J., issued a remand order on the morning of July 3, holding that the notice of removal was not timely filed. (R 974a-76a.)

The jury was reconvened and the matter was tried through July 11, 1997. On July 11, the jury returned a verdict for Unibell on its causes of action for constructive fraud, negligent misrepresentation, unjust enrichment and a violation of Insurance Law section 4226 relating to one of the two policy periods at issue. The jury returned a verdict for Guardian on Unibell's actual fraud and General Business Law section 349 claims, as well as on Unibell's Insurance Law section 4226 claim relating to the other policy period at issue. (R 1268-83.)

In August 1997, Guardian moved in the trial court to set aside the verdict and direct judgment for Guardian, or, in the alternative, for a new trial, once again raising its ERISA pre-emption argument (R 1138a-39a.) In October 1997, the trial court denied Guardian's motion. (Pet. App. B), pointing out that Guardian's argument fundamentally mischaracterized the nature of this case. The court wrote:

> The majority of defendant's argument is based on its notion that the case is about how it reports its claims incurred or potential claims. The simple fact in this case is that plaintiff asserted that the

> method in which defendant sought renewals of the insurance policy was fraudulent and misleading. The causes of action relate to defendant's efforts to enter into a different contract with plaintiff than the one that was expiring. . . . *The fact that Guardian was a claims fiduciary had nothing whatever to do with the representations it made in attempting to sell additional insurance for the following year.*

(Pet. at 6a-7a) (emphasis added).

Guardian did not perfect its appeal to the Appellate Division until September 1998. On December 29, 1998, the Appellate Division affirmed the judgment, holding that "[t]he jury's finding in plaintiff's favor on its causes of action for constructive fraud, negligent misrepresentation, unjust enrichment and violation of Insurance Law § 4226 was amply supported by the evidence. . . ." (Pet. at 2a.) The Appellate Division also held that, even if it were appropriate to consider Guardian's ERISA preemption argument in light of Guardian's failure to raise it in its answer or pre-trial motions, the "preemption claim would still fail since defendant, at the time of the misrepresentations upon which plaintiff's fraud claim is premised, was merely engaged in the sale of additional insurance — an activity plainly subject to State regulation, ERISA notwithstanding — and not acting in a capacity of an ERISA claims fiduciary . . . ." (*Id.*) On February 11, 1999, the Appellate Division denied Guardian's motion for reargument, or, in the alternative, for leave to appeal to the New York Court of Appeals. (Pet. App. C.)

On May 13, 1999, the New York Court of Appeals also denied Guardian's motion for leave to appeal.

(Pet. App. D.) That court correctly recognized that there was no basis for further review of the Appellate Division's unassailable holdings, including its determination that this action is not preempted by ERISA.

REASONS FOR DENYING THE WRIT

I.

THE APPELLATE DIVISION'S CONCLUSION THAT THIS ACTION IS NOT PREEMPTED BY ERISA IS A CORRECT APPLICATION OF WELL-SETTLED AUTHORITY

Like the Appellate Division below, numerous other courts, applying principles clearly enunciated by this Court, have rejected the contention that ERISA preempts claims such as Unibell's, which are premised on misrepresentations made by insurers in the course of selling insurance to employers. The existence of such overwhelming and uniform authority refuting Guardian's position belies any claim that the questions proposed for review by Guardian are "of exceptional importance to ERISA jurisprudence." (Pet. at 24.) Moreover, most of the questions proposed by Guardian (Pet. at i) are not even presented by this case.

A. Unibell's Claims Do Not "Relate To" An ERISA Plan

In *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, __ U.S. __, 117 S. Ct. 1747, 1750-51 (1997), this Court flatly rejected the "strictly literal" view of the phrase "relate to" in the ERISA preemption provision, which the Court had applied in its earlier cases, and to which Guardian apparently

would have the Court return.[3] *Accord*, *California Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A.*, __ U.S. __, 117 S. Ct. 832, 843 (1997) (Scalia, J., concurring) ("applying the 'relate to' provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else"). Rather, the Court held, the phrase "relate to" must be construed in light of the purposes for which ERISA was enacted — principally to protect the participants and beneficiaries of employee benefit and welfare plans. *De Buono*, 117 S. Ct. at 1750-51. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983).[4]

Thus, this Court has made clear that preemption is unnecessary and inappropriate in matters not directly related to plan administration or participant claims for benefits, particularly where a strong state interest is present, such as the state interest in regulation of the insurance industry. *See John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99-100 (1993); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727-30 (1985). Mindful of these policies and objectives, courts have held repeatedly that ERISA does not preempt claims brought by employers against insurance companies and their agents for

3. Congress provided that ERISA "shall supersede any and all State laws insofar as they . . . *relate to* any employee benefit plan" covered by the statute. 29 U.S.C. § 1144(a) (1997) (emphasis added).

4. In *Shaw*, an early case addressing the scope of ERISA preemption, this Court held that a state law is not preempted when it has only a "tenuous, remote, or peripheral" connection with a covered plan. 463 U.S. at 100 n.21. Although *Shaw* suggested in dicta that the phrase "relate to" should be construed "in the normal sense of the phrase," this more expansive approach has now been authoritatively abandoned.

misrepresentations made in connection with the sale of insurance policies, even where certain aspects of the policies are governed by ERISA.

"Denying . . . a state law action based upon misrepresentation by the plan's insurer in no way furthers the purposes of ERISA." *Hospice of Metro Denver, Inc. v. Group Health Ins. of Oklahoma, Inc.*, 944 F.2d 752, 756 (10th Cir. 1991). *See also Morstein v. National Ins. Servs. Inc.*, 93 F.3d 715, 716, 724 (11th Cir. 1996), *cert. denied sub nom. Shaw Agency v. Morstein*, __ U.S. __, 117 S. Ct. 769 (1997) (employer's state law claims against insurance agent and his agency for fraudulent inducement to purchase and negligent processing of the application for an ERISA-governed insurance plan were not preempted by ERISA); *Taylor Forge Engineered Sys., Inc. v. Beauchamp*, No. Civ. A. 98-2572-KHV, 1999 WL 450955 (D. Kan. June 17, 1999) (state law fraud claim based upon misrepresentations made by seller of insurance to prospective purchaser concerning financial viability of existing ERISA-governed plan did not interfere with the goals of ERISA and would not be preempted); *Hardy v. Fisher*, 901 F. Supp. 228, 232 (E.D. Tex. 1995) (suit by employer/purchaser of ERISA-governed insurance policy against seller of policy for fraud does not affect the relationship among ERISA entities, and preemption will not further the congressional goal of promoting the interests of plan beneficiaries or affect the administration of the plan); *Cook Wholesale of Medina, Inc. v. Connecticut Gen. Life Ins. Co.*, 898 F. Supp. 151, 156 (W.D.N.Y. 1995) (ERISA did not preempt plan sponsors' suit in state court against insurance companies for fraudulent and negligent misrepresentation); *DiPietro-Kay Corp. v. Interactive Benefits Corp.*, 825 F. Supp. 459 (D. Conn. 1993) (plaintiff's misrepresentation claims were not preempted by

ERISA since administration of the plan was not implicated); *McDonald v. Houston Brokerage, Inc.*, 928 S.W.2d 633 (Tex. Ct. App. 1996), *cert. denied*, __ U.S. __, 118 S. Ct. 54 (1997) (suit by employer and plan beneficiaries against insurance broker for fraud, misrepresentation and deceptive trade practices was not preempted by ERISA).

These cases uniformly hold that insurance companies are not immune from state regulation of their sales and marketing practices, or from state common law and statutory liabilities, merely because their insurance products are used in the context of ERISA plans. Guardian nonetheless persists in advancing the *non sequitur* that this principle does not apply here because Guardian was an ERISA "claims fiduciary" for purposes of processing the claims of Unibell's employees. The fundamental flaw in Guardian's argument is that Unibell simply did not sue Guardian for any action that Guardian took in that capacity, much less "assault" Guardian's administration of an ERISA plan (*see* Pet. at 9).

Unibell has never contended that Guardian violated any of its duties as an ERISA claims fiduciary, or that Guardian mismanaged or improperly administered its employee welfare plan. Nor has Unibell ever challenged any of Guardian's determinations with respect to the payment of any claims under the plan, including the two bills totaling $500,000 from NYU Medical Center to which Guardian refers (*see* Pet. at 9). Unibell never challenged the interpretation or validity of any of the terms of the plan, nor did it question the consistency of those terms with Guardian's representations in the course of its efforts to sell Unibell a new policy.[5]

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5. Thus, contrary to Guardian's rhetorical musings (Pet. at 12-13), the courts below did not misconstrue the terms of the plan. In fact, they did not construe the plan at all.

Rather, Unibell claimed, and proved, that Guardian deceived Unibell in connection with its efforts to sell Unibell new insurance policies in 1991 and 1992 — misconduct having nothing whatever to do with the administration or terms of any ERISA-governed plan. As the Appellate Division properly held, Guardian, "at the time of the misrepresentations upon which plaintiff's fraud claim is premised, was merely engaged in the sale of additional insurance — an activity plainly subject to State regulation, ERISA notwithstanding — and not acting in the capacity of an ERISA claims fiduciary." (Pet. at 2a.) Accordingly, ERISA does not preempt Unibell's claims. *See Raff v. Travelers Ins. Co.*, No. 90 Civ. 7673, 1997 WL 473282, at *3, n.6 (S.D.N.Y. May 28, 1997), ("[w]hile Travelers might be considered a fiduciary of the Fund with respect to the administration of claims and benefits, it was not a fiduciary with respect to the arms-length, contractual relationship between the parties").

Guardian seeks to bridge this gap by contending that Unibell's claims are preempted by ERISA because Guardian's misrepresentations *referred to* actions (*i.e.*, the payment of claims) taken in an ERISA fiduciary capacity — even though Guardian was not acting as an ERISA fiduciary at the time of the misrepresentations. (*See* Pet. at i). The argument is devoid of merit. In the misleading renewal notices sent to Unibell, Guardian made no reference whatever to the terms of any ERISA plan, nor was it purporting to be acting pursuant to any such plan. An action does not "relate to" an ERISA plan merely because misrepresentations made in a non-ERISA fiduciary capacity happen to refer to acts performed in a fiduciary capacity. As noted, this Court has mandated that the phrase "relate to" be construed in accordance with the congressional goals in enacting ERISA. *De Buono*, 117 S. Ct. at 1750-51. As the cases cited above

have recognized (*see* 16-17, *supra*), the prosecution of state law fraud claims under such circumstances has no material effect on the interests of ERISA plan beneficiaries or on the administration of ERISA plans. *See also Taylor Forge Engineered Sys., Inc.*, 1999 WL 450955 (state law fraud claim based upon misrepresentations made by seller of insurance to prospective purchaser concerning financial viability of existing ERISA-governed plan did not interfere with the goals of ERISA and would not be preempted).

Guardian's argument is essentially that any reference to the payment of claims, regardless of the context or purpose, "relates to" an ERISA plan. But that limitless conception of ERISA preemption has already been authoritatively rejected. Because "everything is related to everything else," preemption would "never run its course" if the phrase "relate to" were to be taken so literally and expansively. *See De Buono*, 117 S. Ct. at 1750-51 & n.7. In any event, such "tenuous, remote, or peripheral" relationships to ERISA plans were never sufficient to trigger preemption, even before this Court's decision in *De Buono*. *See Shaw*, 463 U.S. at 100, n.21.

B. The Cases Cited By Guardian Do Not Support Its Contentions

Guardian relies principally on *Varity Corp. v. Howe*, 516 U.S. 489 (1996), a case cited by Guardian for the first time in its reply brief on its second appeal to the Appellate Division, to support its preemption argument. (Pet. at 13-16, 19.) *Varity*, however, is fundamentally different from this case. Indeed, preemption was not even an issue in *Varity*.[6]

6. The fact that Guardian did not cite this Court's 1996 opinion in *Varity* until it served its second appellate reply brief in January (Cont'd)

In *Varity*, an employer induced its employees to withdraw from the employer's self-funded medical and non-pension benefits plan by deliberately misleading the employees as to the solvency of the subsidiary that would assume those obligations. The employer was also the ERISA plan administrator. The issue before this Court was whether the employer's deception occurred in its capacity as a plan administrator, thereby implicating its fiduciary obligations under ERISA. The Court held that when the employer conveyed benefits information to plan beneficiaries for the ostensible purpose of assisting those beneficiaries in making an informed choice about continued participation in the plan, the employer engaged in "plan-related activity," and indeed, an act of plan "management" and "administration" sufficient under the statutory definition (29 U.S.C. § 1002(21)(A) (1997)) to trigger the employer's ERISA fiduciary obligations. *Id.* at 502.

In *Varity*, this Court expressly rejected the employer's argument "that it was not engaged in plan administration." *Id.* at 504. Here, the trial court determined, as a matter of fact, that Guardian was *not* acting in its ERISA fiduciary capacity when it made misrepresentations to Unibell in its renewal notices.

Guardian's reliance on *Woodworker's Supply, Inc. v. Principal Mutual Life Insurance Co.*, 170 F.3d 985 (10th Cir. 1999) (*cited* in Pet. at 15-16) rests entirely on a classic flaw in logic. In *Woodworker's Supply*, the court held only that an insurer could be liable under state law for

(Cont'd)

1999, belies its suggestion (Pet. at 19) that its belated preemption argument is attributable to the fact that *Varity* purportedly "changed, or at least clarified, significantly, the law in this area."

misrepresentations made in attempting to sell an ERISA-governed plan, where such actions were taken "pre-plan" and not in an ERISA fiduciary capacity. *Id.* at 991. From that narrow holding, Guardian erroneously deduces that all "post-plan" actions by an ERISA fiduciary — regardless of whether or not they were undertaken in an ERISA fiduciary capacity — must therefore give rise to preemption. In fact, the court in *Woodworker's Supply*, expressly *refused* to find that the post-plan claims at issue in that case were preempted by ERISA, on the ground that there was not a sufficient record to determine what the alleged misconduct was. *Id.* at 996. The court thus plainly, albeit implicitly, recognized that state law claims based upon post-plan conduct are *not* necessarily preempted merely because the challenged conduct occurs "post-plan."

Thus, even if Guardian's conduct here were considered to be post-plan, the Appellate Division correctly determined that Unibell's claims were not preempted, since Guardian's ERISA-fiduciary status was not implicated at all by this action. *See Woodworker's Supply*, 170 F.3d at 992 ("a state's 'efforts to prevent sellers of goods and services, including benefit plans, from misrepresenting . . . the scope of their services is quite remote from the area with which ERISA is expressly concerned' ") (*quoting Wilson v. Zoellner*, 114 F.3d 713, 720 (8th Cir. 1997)).[7]

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7. Guardian argues that, even though the trial court ruled on the merits of its ERISA preemption claim, the court erred by criticizing Guardian for failing to raise the issue earlier and by not recognizing the non-waivability of Guardian's preemption defense. (Pet. at 15 n.5.) Guardian is wrong on both counts. First, the trial court correctly recognized that Unibell's allegations concerning Guardian's misleading "incurred claims" figures, had been in the

(Cont'd)

C. Unibell's Claims Do Not Implicate The Administration Of Any ERISA Plan

Guardian asserts here, for the first time, that this action implicates ERISA because the evaluation of Unibell's claims required an interpretation of the ERISA-governed plan. Specifically, Guardian contends that it was necessary to make reference to the plan's definitions of the terms "charge" and "claim" in order to determine whether or not the incurred "claims" figure in Guardian's 1991 renewal notice to Unibell was misleading. (Pet. at 4, n.3, 6-8, 16-17.)

Guardian's contention should be rejected for its failure to assert it below, *United States v. New York Telephone Co.*, 326 U.S. 638, 651 n.18 (1946), and because it is, in any event, erroneous. Nowhere in Guardian's 1991 renewal notice, sent to persuade Unibell to enter into a new contract, did Guardian purport to be interpreting, much less administering, an ERISA plan. The 1991 letter made no reference to the terms of the existing contract and certainly did not refer the reader to the plan for the definition of "incurred claims" or any other term.

Moreover, Unibell's claims did not turn on any interpretation of the existing contract. Dr. Turndorf testified

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(Cont'd)
case for many months. (R 6-7.) Further, ERISA preemption, if not timely asserted, is in fact waived. *See Allen v. Westpoint-Pepperell, Inc.*, 11 F. Supp. 2d 277, 283 (S.D.N.Y. 1997) (ERISA preemption is a waivable affirmative defense — it is merely a choice of law provision, not jurisdictional); *Adsit v. Quantum Chem. Corp.*, 199 A.D.2d 899, 900 (3d Dep't 1993) (ERISA preemption is a waivable affirmative defense). Thus, Guardian's waiver of the preemption defense constitutes an additional reason to deny its petition for *certiorari*.

that, based solely on Guardian's 1991 renewal notice, he understood Guardian to be describing the cost of care that was provided to Unibell employees during the time period referenced in the letter. (R 91.) Unibell's expert confirmed that Dr. Turndorf's understanding was in fact the common understanding in the industry (R 744), and Guardian's own witnesses testified to employing the term in the manner understood by Dr. Turndorf. (R 602-03, 708-09, 864.)

In short, any distinction in the existing contract between the terms "charge" and "claim" had nothing whatever to do with Guardian's misrepresentation of the amount of "incurred claims" in attempting to sell new insurance to Unibell. The jury simply was not required, asked or instructed to base its decision on an interpretation of the plan. Therefore, the second of Guardian's "questions presented" (Pet. at i), concerning whether an action to interpret an ERISA plan may be maintained in state court, is not a question that is presented by this case.

D. The Judgment Does Not Implicate In Any Way The Finances Or The Reporting Requirements Associated With ERISA Plans

Guardian erroneously maintains that this case implicates ERISA because the judgment prevents Guardian from taking into account all claims paid in the most recent fiscal year when proposing a renewal, if the claims were for medical services rendered in a prior year. (Pet. at 13, 18.) Indeed, Guardian goes so far as to assert that it "pays approximately 285 million dollars annually for claims for medical services received by insureds during earlier years" and that the judgment, if allowed to stand, would therefore "create financial havoc for ERISA plans." (Pet. at 18, *see also* Pet. at 7-8, n.4.)

This case has never been about whether the renewal premiums proposed by Guardian were appropriate. Guardian may calculate a policyholder's experience, and determine the premium it will charge, in any manner it chooses. The judgment simply holds Guardian accountable for deceiving a prospective policyholder.[8]

Guardian also incorrectly asserts that the judgment, if allowed to stand, will force Guardian to report claims differently in New York than in the rest of the country. (Pet. at 18.) The fallacy of that argument is clear — ERISA has nothing whatever to do with the content of Guardian's renewal letters. As the trial court correctly noted:

> [T]here is no ERISA requirement that defendant submit any claims data in its request for a renewal policy. The decision to include claims data is one that Guardian chose for itself and this action related to the inadequacy and misleading nature of that data. It did not impact required reporting or the payment of any claims.

(Pet. at 7a.)

Thus, as correctly recognized by the trial court, the judgment does not require Guardian to report its claims

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8. Guardian erroneously asserts that Unibell's expert challenged Guardian's administration of the plan when he purportedly testified that, "when computing premium rates for the next policy year, Guardian should not have considered any amounts paid during the prior policy year for services received by Unibell insureds during earlier policy years." (Pet. at 7.) The cited portion of the record (R 773) contains no such testimony. In fact, Unibell's expert expressly disclaimed that position. (R 769-70.)

experience at all in its renewal letters. Nor does ERISA. Indeed, most often, Guardian does not report such information. Therefore, the third of Guardian's "questions presented" (Pet. at i), concerning whether an action may be maintained in state court to determine what information must be disclosed by an insurer during the course of the renewal of an ERISA plan, is also a question that is not in fact presented by this case.

E. The District Court Remand Order Did Not Reach The Question Of ERISA Preemption

Guardian contends that, because Judge Martin of the United States District Court for the Southern District of New York never addressed the substance of Guardian's ERISA preemption argument in remanding the case to state court, the district court must have decided that issue in Guardian's favor. (Pet. at 5, 18-20.) This utterly ridiculous argument ignores the obvious reason why the district court had no need to reach that issue. Under federal law, Guardian had thirty days to remove the case once it received notice of the possible grounds. *See* 28 U.S.C. § 1446(b) (1997). Contrary to Guardian's assertion that the issue that purportedly rendered the action removable was not in the case until the day of trial (Pet. at 3, 18-20), the state court found (and Judge Martin agreed), that the issue had been in the case for months. Thus, a remand was required and it was not necessary to (and Judge Martin did not) rule on the merits of Guardian's preemption argument.

II.

THE APPELLATE DIVISION'S ORDER DOES NOT GIVE RISE TO ANY QUESTION CONCERNING ERISA'S "SAVINGS CLAUSE"

Attempting to create the appearance of an issue worthy of granting a writ of *certiorari*, Guardian argues (Pet. at 20-23), without one iota of support from the text of the December 29, 1998 Order (Pet. App. A), that the Appellate Division based its decision on the statutory exemption from ERISA preemption applicable to state laws that regulate insurance. (*See* 29 U.S.C. § 1144(b)(2) (1997).) In fact, the limitation on ERISA preemption for state laws regulating insurance was not relied upon — or even mentioned — by Unibell in its brief to the Appellate Division, was obviously not relied upon by Guardian, and was not cited by the Appellate Division anywhere in its memorandum decision.[9] Guardian raised the point for the very first time in its motion to reargue.

In any case, the statutory exemption to ERISA preemption is entirely beside the point. The Appellate Division expressly recognized in its Order that Unibell had charged Guardian with wrongdoing in its capacity as a seller

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9. Guardian purports to glean from page references to two cases cited in the Appellate Division's Order that the court's decision was actually based on that exemption. (Pet. at 20-21.) In fact, Unibell had correctly cited to precisely those pages in its appellate brief (at 29) only as support for the proposition that ERISA preemption is "inappropriate in matters not directly related to plan administration or participant claims for benefits, particularly where a strong state interest is present, such as the state interest in regulation of the insurance industry." That is exactly the point for which the Appellate Division cited to those pages as well.

of insurance, not as a claims fiduciary, and that ERISA's preemption clause therefore did not apply. (Pet. at 2a.) The court was thus not required to reach, and did not reach, the question of whether, if Unibell's claims were otherwise preempted, there might be some exception that would apply.

As the Appellate Division's Order had nothing whatever to do with the statutory exemption to ERISA preemption, Guardian's discussion of *Unum Life Insurance Co. of America v. Ward*, __ U.S. __, 119 S. Ct. 1380 (1999), along with the rest of its discussion of ERISA's "savings clause" (Pet. at 21-22), is utterly beside the point. This case does not present that issue.

Finally, Guardian distorts the holding of *DeBruyne v. Equitable Life Assurance Society*, 920 F.2d 457 (7th Cir. 1990) (*cited* in Pet. at 21-22). In *DeBruyne*, plaintiffs were plan beneficiaries who alleged that the plan documents themselves contained misrepresentations. The court concluded that a claim under N.Y. Insurance Law section 4226 by plan beneficiaries *based on misrepresentations in the plan documents themselves* was preempted by ERISA and not saved by the statutory exemption for laws that regulate insurance. 920 F.2d at 468. By using section 4226 specifically to challenge ERISA plan documents, the plaintiffs in *DeBruyne* brought themselves into direct conflict with ERISA, which also provided a remedy for such misrepresentations. *Id.* at 470 (*citing* 29 U.S.C. § 1104(A)(1)(b) (1997)). In fact, the plaintiffs had alleged a violation of that very provision of ERISA in their complaint. Thus, plaintiffs' state law claim and their ERISA claim were virtually identical.

Contrary to the picture that Guardian attempts to paint, the court in *DeBruyne* did not hold that section 4226 was generally preempted by ERISA. Rather, the court held only that "the *specific* application of section 4226(a)(1) advocated by plaintiffs [was] preempted." *Id.* at 470 n.27 (emphasis added). Given the materially different claim under section 4226 that was raised by Unibell here, the *DeBruyne* case provides no support whatever for Guardian's contention that Unibell's claim was preempted. Moreover, the *DeBruyne* court's discussion of the statutory exemption to preemption is, like the same discussion in *Unum Life Ins. Co.*, wholly irrelevant, as it addresses a matter that has no bearing at all on the Appellate Division's decision in this case.[10]

In sum, the fourth of Guardian's "questions presented," concerning the applicability of the statutory exemption to ERISA preemption (Pet. at i) is likewise not a question that is in fact presented by this case.[11]

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10. Guardian also appears to argue that N.Y. Insurance Law Section 4226 is generally preempted because it provides for a remedy that is not available under ERISA. (Pet. at 22, *citing Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53-56 (1987).) Guardian is misreading *Pilot Life*. Whether a state law claim is pre-empted depends on whether it "relates to" an ERISA plan. There is nothing in the *Pilot Life* decision that suggests that the remedies available under the state law claim are a factor in that inquiry.

11. Guardian also takes issue with the fact that Unibell was awarded punitive damages. (Pet. at 22, *see also* Pet. "questions presented No. 5" at i.) The propriety of that award is not properly before this Court. Whether Unibell's substantive claims are preempted is not a function of the remedies available under state law. Because Unibell's claims are not preempted, there is no federal issue presented by this case with respect to punitive damages. Thus, the fifth of Guardian's "questions presented" does not provide a basis for this Court to issue a writ of *certiorari*.

CONCLUSION

For all the foregoing reasons, Guardian's petition for a writ of *certiorari* should be denied.

Respectfully submitted,

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No. 99-249

IN THE
Supreme Court of the United States

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA,

Petitioner,

v.

UNIBELL ANESTHESIA, P.C.,

Respondent.

ON PETITION FOR A WRT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF NEW YORK, APPELLATE DIVISION, FRST DEPARTMENT

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FURTHER REASONS FOR GRANTING THE WRIT

I.

RESPONDENT'S BRIEF CONTAINS NUMEROUS MISSTATEMENTS.

Respondent makes numerous factual errors in its brief. Several are particularly relevant to the petition.

On page 2 respondent presents three contentions implying that these were the discrete issues submitted to the jury. The record, however, indicates that ERISA related "incurred claims" issues were central to the charge and inextricably intertwined with Unibell's claims. (1188-1198).[1] There were no independent state law theories of recovery. The Medicare allegations were incorporated into the ERISA theory, with an instruction to the jury that Unibell claims that Guardian should have disclosed the Medicare status of Greta Filler "to avoid making a disclosure of the incurred claims figures not misleading" (1189).

The allegations in paragraph (iii) on page 2 of the respondent's brief concerning the broker were not proven at trial and were not submitted to the jury.

On page 3, and at several points thereafter, respondent states that Guardian took two appeals below to the intermediate Appellate Division. One appeal concerned the pretrial motion for summary judgment. The second was the subject appeal. Respondent states (*e.g.*, on page 3) that Guardian did not present appellate ERISA issues until the second appeal, implying that this issue was untimely. The contention is also made on page 3 that ERISA preemption was not raised until the case had been litigated for "more than two years."

Despite Unibell's suggestions to the contrary, the ERISA preemption issue was raised in a timely fashion. Guardian moved for summary judgment on the state law based causes of action alleged in the original amended complaint. Only state law issues were presented. The denial of this motion was appealed to the

1. References are to the pages of the record on appeal to the New York Supreme Court, Appellate Division, First Department.

Appellate Division, which affirmed. 239 App. Div. 2d 248 (1st Dept. 1997). The appeal was concluded months before Unibell sought to amend its complaint to inject the ERISA-related "incurred claims" issue.

During that appeal respondent *for the first time* briefly raised the then unpleaded arguments concerning the incurred claims renewal letter issues. Under New York law unpleaded matters may be raised as a defense to a motion for summary judgment. *See, e.g., Denburg v. Parker Chapin Flattau & Klimpl*, 213 A.D.2d 297 (1st Dept. 1995). Guardian could not object to such submissions under state law.

It is an entirely different issue whether the action could have been removed during the first appeal based upon a mere reference to an issue in a brief. With limited exceptions removal issues must be raised in pleadings. *See Crump v. Wal-Mart Group Health Plan*, 925 F. Supp. 1214, 1217-19 (W.D. Ky. 1996), where the court rejected the argument that the time for removal commenced when federal issues were raised on a state court motion. Instead, the time for removal was found to run from the amendment of the complaint.

Under state law, an amendment to the complaint was required to raise affirmatively these new charges. Respondent delayed moving to amend until the time of trial, and the motion was granted moments before the trial actually commenced (10). The new allegations were that the claims reported in the 1991 renewal proposal included claims for medical services rendered during years before the period specified in the letter. It was also contended that claims were double-counted — *i.e.*, for the year the services were rendered and for the year paid by Guardian (60a). Intentional misrepresentation of ERISA fiduciary payments was alleged. Guardian immediately sought removal. Any earlier attempt to remove based upon the mention of such matters in respondent's brief submitted on appeal from the denial of summary judgment would have been sanctionable.

The argument of respondent on pages 21-22 that ERISA *subject matter jurisdiction* preemption claims are waived by

untimely assertion is completely erroneous in any event. The cases cited by respondent involved ERISA benefit claims which may be brought either in federal or state court. *See Wolf v. Reliance Standard Life Ins. Co.*, 71 F.3d 444 (1st Cir. 1995), relied upon in the district court case cited by respondent on page 22, where the distinction between such cases and "nonwaivable" subject matter jurisdiction issues was emphasized. "Our holding is limited to ERISA preemption of benefits — due actions. ERISA permits several other types of civil actions (e.g. for injunctive relief, for breach of fiduciary duty, etc.) subject to exclusive jurisdiction in the federal courts rather than concurrent jurisdiction." *Id.* at 449, n.8. Jurisdiction over ERISA fiduciary breach claims lies exclusively with the federal courts. 29 U.S.C. § 1132(e).

On page 6, respondent presents irrelevant factual contentions concerning Medicare related issues. It is submitted that focus should not be diverted to such factual issues. These matters can be addressed in a federal district court trial where the claims of ERISA fiduciary breach should be resolved. At such a trial Guardian will establish that the causes of action which could be asserted under ERISA have no merit. These matters, however, are completely irrelevant to the jurisdictional issues presented in the petition.

II.

THE SUPREME COURT SHOULD REVIEW THE RULE OF LAW DECLARED BY THE STATE COURTS.

Respondent candidly admits that the state courts held that they had jurisdiction to determine an action seeking damages based upon allegations that, during the renewal of a plan, an ERISA fiduciary misrepresented acts performed in a fiduciary capacity. *See* page 18 of the respondent's brief where this result is sought to be upheld by a mistaken reading of the ERISA "relate to" concept — a reading which is completely at odds with *Varity Corp. v. Howe*, 516 U.S. 489 (1996), discussed in the petition. As discussed at page 11 of the petition, acts relate to an ERISA plan, and are preempted from being the subject of

a state court suit if state regulation of such matters would impede the nationally uniform administration of ERISA plans. *Indeed, on page 18 of its brief respondent concedes that the claims information set forth in the 1991 renewal letter "refer[s] to acts performed in a fiduciary capacity." See also* page 8 of the respondent's brief where it is contended that the Guardian underwriters deliberately provided erroneous claims data "to persuade Unibell to renew" the plan.

On page 20 respondent acknowledges that *Varity* held that supplying ERISA plan related information to persuade persons or entities to remain in a plan is an act of plan administration, implicating fiduciary obligations. The rule cannot be otherwise where, as here, such allegedly false information is provided by an ERISA insurer/fiduciary during the renewal of a plan. The rule would presumably apply during the regular renewal of insurer issued ERISA plans. An ERISA insurer is entitled to the benefit and protection of a trial of such allegations in the proper forum where state tort law passions are absent. The greater burdens imposed upon ERISA fiduciaries by federal law requires a proper forum for the resolution of disputes between ERISA entities. Allegations constituting charges of ERISA fiduciary breach should not be decided in a typical state court tort jury environment.

On pages 20-21 respondent argues that the federal courts have not imposed a blanket rule that state law resolution of all ERISA plan renewal claims is preempted. This, however, is not the rule advanced by petitioner. Petitioner instead urges this Court to adopt a rule that any claim that an ERISA fiduciary deliberately provided false plan related information to seek to induce renewal is so related to plan administration under *Varity* that the federal courts must determine the law under which such actions are to be resolved. The affirmed finding of the trial court on the post trial motion that ERISA plan renewal fraud claims are not preempted, discussed at page 13 of the respondent's brief, should be set aside by this Court.

Respondent makes several misstatements concerning *Varity*. On page 19 respondent claims that *Varity* was not a preemption case. However, the issue addressed in *Varity* was whether federal jurisdiction existed under ERISA to remain in that venue. This is the same question presented in a preemption defense raised in state court. *See Farr v. U.S. West Communications, Inc.*, 151 F.3d 908, 913 (9th Cir. 1998), where *Varity* was relied upon in the court's preemption analysis.

In *Varity* this Court rejected arguments that providing information not required by ERISA's disclosure rules, to seek to induce renewal, precluded a finding of plan administration. *Varity*, 516 U.S. at 504. Consequently, the trial court's finding in the present action that preemption is precluded because ERISA did not require the inclusion of claims data in a renewal proposal is in direct conflict with *Varity*. *See* page 24 of respondent's brief for discussion of trial court's finding. Equally erroneous under *Varity* is the post-trial finding, discussed on page 13 of the respondent's brief, that the claims representations were unrelated to Guardian's ERISA fiduciary status. Unless this decision is reversed, Guardian will remain subject to suit in New York state courts for allegedly inaccurate reporting of ERISA claims payments in renewal proposals. At least 25% of the claims paid annually by Guardian are for medical services rendered during earlier policy years (826-27).

The argument of respondent on page 17 that a party can avoid ERISA preemption by pleading only state law causes of action concerning ERISA plan related activities is erroneous. Where there is complete federal preemption of a specific area of the law, any complaint purporting to raise a state law claim in such area is preempted. The "well pleaded complaint rule" does not apply under such circumstances. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66-67 (1987), where it was held that causes of action pleaded under state law seeking to enforce what were, in reality, ERISA claims were "necessarily federal in character by virtue of the clearly manifested intent of Congress" and were removable by the defendant. *See also Smith*

v. Provident Bank, 170 F.3d 609, 613-14 (6th Cir. 1999), applying this rule to a state law claim of breach of ERISA fiduciary duty.

The respondent states on pp. 26-27 that the "Appellate Division expressly recognized in its order that Unibell had charged Guardian with wrongdoing in its capacity as a seller of insurance, not as a claims fiduciary, and that ERISA's preemption clause did not apply." This is a candid admission that the state court failed to apply the well pleaded complaint rule discussed at page 24 of Guardian's brief to that court. There can be no exception to this rule, as implicitly urged by respondent, simply because the alleged breach occurred during the renewal of an ERISA plan. Federal law, not state pleading rules, must determine this case.

III.

THE SUPREME COURT SHOULD DECLARE THAT ACTIONS AGAINST AN ERISA FIDUCIARY REQUIRING AN INTERPRETATION OF THE TERMS OF AN ERISA PLAN CANNOT BE MAINTAINED IN THE STATE COURTS.

As discussed in the petition, respondent contended at trial that Guardian deceived it by using the term "incurred claims" in the 1991 renewal letter. This is not disputed by respondent. *See, e.g.*, pages 22-23 of the respondent's brief, where it is stated that Dr. Herman Turndorf, the president of Unibell, "understood Guardian to be describing the cost of the care that was provided to Unibell employees during the time period referenced in the letter." It is further argued on page 23 that "Unibell's expert confirmed that Dr. Turndorf's understanding was in fact the common understanding in the industry." Respondent also asserts on page 23 that a Guardian's witness also used the term in the sense understood by Dr. Turndorf.

It is submitted that, at this point, the relevant issue is not whether Guardian did in fact intentionally mislead respondent in the renewal letter. This is another factual question that can be addressed in a federal action. The issue of importance is the

threshold question of whether a state court has jurisdiction over a tort action which must involve an analysis of an ERISA plan. Reference to the ERISA plan was necessary in order to determine whether, as contended by Guardian, the term "incurred claims" was correctly used. *See, e.g.*, pages 825-26 of the record, where a Guardian officer referred to the policy to defend the use of "incurred claims" in the 1991 renewal letter. When Dr. Turndorf and the respondent's expert confused the concepts of a medical charge and a claim, they were describing a situation in conflict with the ERISA plan. Most importantly, the issue should be addressed whether ERISA can allow a rule of law which would permit suits for fraud or other state torts in state court based upon an interpretation of plan terminology. It is submitted that the meaning of ERISA plan provisions must be determined pursuant to the federal common law. Whether an ERISA fiduciary used plan related terminology to deliberately deceive one owed a fiduciary obligation must be a federal question. As stated in *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 213-14 (1985), discussed on pages 16-17 of the petition, that the issue of whether a state tort "is sufficiently independent of federal contract interpretation to avoid preemption, is, of course, a question of federal law." Respondent ignores this rule's obvious application to this action.

It is disingenuous for respondent to argue on page 17 that it never challenged any determination made by Guardian, as an ERISA fiduciary, to pay the two N.Y.U. claims. Respondent also states on page 17 that it never questioned the consistency between the policy terms and the 1991 renewal letter. Both of these contentions ignore the obvious interrelationship between the policy provisions concerning when a claim or a charge is incurred, (petition, page 4) and the respondent's contention that these terms had legally cognizable meanings unrelated to the ERISA plan.

Guardian's contention that preemption flows from the need to interpret the plan is not a new argument, as claimed by respondent on page 22 of its brief. Guardian has argued

consistently since the day the trial commenced, when the incurred claims allegations were added, that ERISA preemption applied for the reasons discussed in this point. *See, e.g.*, page 26 of Guardian's brief to the Appellate Division discussing the preemptive effect of the fact that the Unibell claims cannot be evaluated without a reference to the plan. Point II(c) of Guardian's brief in support of the motion for leave to appeal to the state Court of Appeals was captioned "The Incurred Claims Allegations Of Unibell Cannot Be Evaluated Without Reference To The ERISA Plan And Are Consequently Preempted."

In addition, this argument would be proper in support of the petition in any event since ERISA preemption had been raised below. It is not disputed that this issue predominated at the trial and on appeal. "Once a federal claim is properly presented, a party can make any argument in support of that claim; parties are not limited to the precise arguments they made below." *Yee v. City of Escondido*, 503 U.S. 519, 534 (1992). There is no basis under applicable law for respondent to raise a "new argument" contention under these circumstances.

IV.

THE STATE COURT AND RESPONDENT MISAPPLY ERISA'S "SAVINGS CLAUSE".

As shown on pages 20 *et seq.* of the petition, the Appellate Division misapplied the ERISA "savings clause" to avoid preemption of respondent's common law and statutory causes of action. On page 26 of its brief, respondent claims that the state court did not apply the "savings clause," but rather adopted that part of respondent's brief which argued that ERISA preemption is "inappropriate in matters not directly related to plan administration or participant claims for benefits, particularly where a strong state interest is present, such as the state interest in regulation of the insurance industry." Respondent acknowledges on page 26 that the two cases cited by the Appellate Division in its decision were also cited by respondent in its brief as authority for the quoted statement.

It is quite apparent that the quotation above is a description of the circumstances under which the ERISA "savings clause" has been applied by this Court. *See, e.g., John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99-100 (1993), cited by respondent and by the Appellate Division, where this Court declared that, while ERISA generally preempts all state laws which "relate to" ERISA plans, "[s]tate law governing insurance generally is not displaced" unless that law "stands as an obstacle to the accomplishment of the full purposes and objectives of Congress . . ." (citations omitted). In cases of direct conflict ERISA prevails pursuant to the Supremacy Clause. *Id.* at 100. Respondent's argument is simply another way of stating the principle, codified in the "savings clause," that ERISA does not preempt state insurance laws which regulate insurance unless such laws directly conflict with ERISA.

In reality, therefore, respondent made a "savings clause" argument, without attaching that label, and the state court accepted this argument as the basis for its rejection of Guardian's preemption arguments! Yet, for the reasons discussed in the petition, the "savings clause" was inapplicable to this case.

Nowhere in its brief does respondent dispute the fact that all of the state common law and statutory causes of action upon which it recovered fell outside of the absolute requirement that the "savings clause" only applies to state laws directed to the insurance industry. Respondent's attempt to distinguish this case from *DeBruyne v. Equitable Life Assurance Society*, 920 F.2d 457 (7th Cir. 1990), discussed at pages 21-22 of the petition, must fail. Any factual differences are irrelevant since respondent does not dispute that § 4226 of the Insurance Law, at issue here and in *DeBruyne*, is simply the codification in an insurance statute of what would otherwise be an applicable general rule of New York common law. Such statutes are not protected from preemption by the "savings clause." *Unum Life Ins. Co. of America v. Ward*, __ U.S. __, 119 S. Ct. 1380 (1999). See page 21 of the petition.

CONCLUSION

The petition should be granted.

Respectfully submitted,

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